JUL 1 1938

Merohal Liberty



VOLUME 51 JULY 1938

NUMBER 1

IRON ARM

the Surgeons' Needle that is UNIFORM in TOUGHNESS, RESILIENCY and HARDNESS



To secure a surgeons' needle that was always uniform—in Toughness, Resiliency and Hardness—one where every needle used was exactly like the last in every respect, we went to England.

Here was a needle manufacturer—MIL-WARD'S of Redditch—who had been famous for more than 200 years. When Milward turned to the manufacture of IRON ARM Surgeons' Needles they brought to the surgical field the wealth of two centuries of experience of fine needle-making.

The Secret of UNIFORMITY of IRON ARM Needles

Here was an unusual combination: experience, equipment, processes and standards—the essentials required in producing absolute consistency in the quality of needles. But Milward's scientific control of every stage of manufacture—from the raw material to the finished product—is the true secret of UNIFORMITY in IRON ARM Needles. For when every step of the procedure is so uniform and constant the final result will be uniform.

Here are some of the controlled steps of manufacture which assure IRON ARM needle Uniformity:

Uniform Steel: The raw material that is used in IRON ARM Needles is made uniformly—to a special formula—by one of Sheffield's oldest houses. Even so it is constantly checked by chemical analysis at the Milward plant.

Special Machinery: Designed by Milward to produce absolute uniformity is used—to draw the wire, to "make" the needle.

Uniform Tempering: Tempering and hardening that insure absolute uniformity are obtained in the special electric-heating furnaces, scientifically controlled by the aid of pyrometers.

Uniform Finishing: The finish on IRON ARM Needles is uniformly applied in accordance with set standards, the result of long experience. Microscopic inspection of the "mirror finish" maintains rigid control and assures uniformity.

Uniform Control: Rigid control throughout every stage of manufacture—control of raw material; control of processes by every known scientific aid; control of the result by every modern test.

Thus it is easy to see that such uniformity of procedure and inspection—from the raw material to the finished product—would produce a needle of extraordinary UNIFORMITY. It has.

That is the Surgeons' Needle we invite you to test: IRON ARM. Check it for uniform Toughness, Resiliency and Hardness. Now available through your surgical instrument dealer in most sizes and types.

Sole Distributors in the Americas for IRON ARM Surgeons' Needles

MacGREGOR INSTRUMENT COMPANY + Needham, Mass.

Makers of VIM Hypodermic Needles and VIM Syringes

ORDER IRON ARM Needles through your regular Surgical Instrument Dealer

HOW 2 HOSPITALS

attempted to cut laundry costs

AND WHY ONE FAILED!

No. I

decided to "retrench"; to make old, out-dated equipment serve a few more years. Cheaper labor was hired—cheaper materials were used—machines were patched and repaired and patched again with a prayer that they would hold together without mishap.

RESULT: Operating costs continued as before, due to breakdowns and frequent repairs. Spoilage increased, due to inefficient operation and rapid deterioration, thus increasing linen replacement costs. Quality of work grew consistently worse.

No. 2

decided to scrap all obsolete machines which were found to be costly in operation—and install new, high-speed Smith-Drum equipment.

RESULT: Greater efficiency, lower labor costs and operating expenses to the point where savings actually paid for the new equipment. Breakdowns elimininated. Modern equipment and decreased depreciation reduced expenditures for linen replacement to a minimum. Finished work much higher in quality than ever before.

This Plan Can Work in Your Hospital Laundry Too
—Write for Details

SMITH, DRUM & COMPANY

PHILADELPHIA, PA.

Manufacturers of a Complete Line of Modern Laundry Equipment

WITH THE ROVING REPORTER

If You've a House Organ

• Those hospitals that are public relations minded to the point of publishing a paper, or house organ, would do well to heed what happened recently in Pittsburgh. If the lay public is to be made intelligent on hospital services, what better place to start than in the schools?

This logical question raised by Harry Stanley, director of publicity of the Hospital Association of Pennsylvania, led to the suggestion that two high schools be asked to pick from the editorial staffs of their school papers a few pupils who might come into two hospitals, at about the same time, and gather material from the outside point of view that would comprise a complete edition of each of the bulletins regularly issued by the two hospitals.

Copies of these editions were to be distributed to the two student bodies so that parents could see for themselves the impressions of the hospital world gained by the voung writers.

The two hospitals agreeing to participate were the Western Pennsylvania Hospital and the Allegheny General Hospital. What phases of the hospital picture do you suppose these youngsters described? In the "Allegheny General News" they wrote about blood donors, basal metabolism, the children's ward, visitors and the laundry. One of the pupils interviewed a student nurse to find out what her work is like, another delved into the record room while others described the boiler room and the emergency department.

In the "West Penn News" the pupils not only presented descriptive bits about the hospital work but furnished their own illustrations. The vasculator won first page mention. Food, supplies and the dietetic kitchen were singled out for editorial treatment, as were the laboratory, the social service, surgical and x-ray departments and Christmas festivities. As some indication of the journalistic ability employed, the Roving Reporter quotes a few lines under the heading "Nursing."

ing."

"It was 6 a.m. Faint outlines of the Western Pennsylvania Hospital took form through a thick fog in early February. Electric lights, like illumined pin points, shone in the semi-darkness.

"There was activity, diligent and vigorous, in the nurses' home. Gone were the quiescent hours of night; in their place a period of brisk, energetic preparation. In the near-by hospital, white gowned nurses busily carried



Nourishment cart at Atlantic City Hospital, Atlantic City, N. J., with nurses' aid and nurse.

out their numerous duties, assisting and comforting their patients.

"For the hospital day never ends. From early morning till late at night, the hospital is awake to the necessities and wants of every patient, whether a man in the autumn years of life or a baby gazing at the noisy world he has so recently entered.

"During the training period, the 108 nurses enrolled at the Western Pennsylvania Hospital School of Nursing are given illustrated lectures and demonstrations in the different fields of hospital work. Each student must spend a total of 1341 hours in such divisions as surgical nursing, medical nursing, pediatrics, obstetrics and public health.

"Nursing means certain sacrifices but the satisfaction and pride derived make these sacrifices seem trivial.

"We shall take a student nurse, let us say Marie Stevens. This week her shift is 7 a.m. to 1 p.m. and 4 p.m. to 7 p.m., with time out for meals."

To say that the parents of these pupils were impressed is to put it mildly. Faculty advisers, too, welcomed the opportunity for their pupils to participate in such an outside project. So far as the pupils were concerned, one of them wrote: "A new world opened . . . a world that we never knew existed, so complicated in its differing phases that a mere outsider has a hard time getting a clear idea of what it consists."

"Ellis News" Appears

 Mention of hospital house organs reminds us that introductions are in order. This time it is "The Ellis News," sponsored by the Ellis Hospital, Schenectady, N. Y., that takes a bow.

We're a bit late in making this announcement, for the little publication is now six months old. Five hundred copies are being distributed, we are told, to the staff nurses, board members, voluntary workers and employes. Offset printing is used because it is less expensive than type. Economical use of pictures brings the cost to about \$50 an issue. So "newsy" are the four pages with their many different small items that the lack of illustrations proves no handicap. Incidentally, Margaret Waldron, housekeeper, is editor.

The Nourishment Cart!

• The next best thing to the ice cream sandwich man who serves frozen delicacies along the highways and byways of our countryside is the extra nourishment cart that is rolled about the floors of the Atlantic City Hospital, Atlantic City, N. J.

Ins

ter

lab

ph

"he

suc

sur

pli

no

the

tio

ad

pit

su

pu

up

m

be

Bo

of

fie

tw

ho

in

All liquid diets are centralized, Crystal Roney, dietitian, tells us. Instead of sending these to the floors each morning in quantities for the day, the cart, with a student nurse and a nurses' aid in charge, now makes the rounds of each floor at three hour intervals, 9, 12, 3 and 6 o'clock, day and night. Chocolate milk, plain milk, pineapple juice, apricot nectar, chicken broth, eggnogg, fruit gelatins and custardsthese and any other liquids that may be requested are included with the necessary service. On the patients' beds are pinned cards of different color for the different orders of liquids.

"The nurses look for the cards," Miss Roney tells us, "and serve according to color which they designate. Only the patients that have cards on their beds are served."

Tea on Tuesdays

• Should you happen to be in Atlantic City on the first Tuesday of the month, drop around to the hospital and ask Miss Roney to show you the tea table which the student nurses set up for the alumnae tea. The food, as well as the table, is prepared by the students. The menu usually consists of any one or a combination of assorted sandwiches, cookies, cup cakes, ices, ice cream, fruit-ades and tea.

"It creates a feeling of self-assurance and prepares them along with their other nursing training to meet all problems that confront them as a graduate nurse," Miss Roney points out.

LOOKING FORWARD

What Is Hospitalization?

A RECENT enabling statute in Pennsylvania permits the organization of groups to supply hospital care insurance to the residents of that commonwealth. Institutional boards and executives believe that the term "hospitalization" includes bed and board, and laboratory, physical therapy and x-ray services. Some physicians, on the contrary, contend that the term "hospitalization" implies that only bed, board and such laboratory services as interns and technicians may supply, *i.e.* urinalyses and blood counts, may be supplied. As reported in our news columns, the issue has now been taken into court.

On the legal interpretation of this term, may hang the future of hospital care. A narrow cramping definition may deny needed care to many thousands. An adequate definition, in line with sound accepted hospital practice, will permit a well-rounded service to subscribers and their dependents. It also will probably put a stop to the needless attacks by medical societies upon hospitals for doing the very things that national medical standardizing bodies require. May this issue now be settled once and for all!

Neither the hospital council nor the physician should be charged with being activated by ulterior motives. Both, no doubt, believe themselves right. But while officials fiddle over words the patient's disease blazes fiercely. The tragic result of such a war of words between physicians as a group and the public and its hospital is that lives may be lost while a matter involving no great moral principle is being debated.

The creed of the doctor and the hospital should make such a sorry spectacle impossible. Both are sworn to save life, to forget self and to remember only the patient's plight. The confidence of the public cannot but be shaken by dragging into the legal spotlight a controversy which so vitally affects the health and welfare of the community.

Federal Funds for Hospitals

HOSPITALS that legitimately need additional or modernized physical plants but cannot now afford them should immediately consider the possibility of obtaining federal aid through the Public Works Administration or the Reconstruction Finance Corporation.

The new appropriation to the PWA again makes available a substantial sum for grants or loans to useful and necessary projects. Hospitals that are owned by state, county or city governments may obtain a grant of up to 45 per cent of the cost of a building project and a loan for the balance. Voluntary hospitals, also, if they serve a genuine community need and receive some support from tax funds, probably may receive loans for all or part of the cost from either PWA or RFC. These loans carry 4 per cent interest and usually allow from twenty to thirty years for repayment.

There has been some criticism that PWA loans and grants involve more red tape than they are worth. Careful inquiry among architects who have had experience with the PWA seems to indicate that the following conclusions are justified:

- 1. There is no interference with competent planning. Plans submitted by an experienced hospital architect will not be altered or captiously criticized. If the plans are considered inferior, the application will be refused.
- 2. No systematic attempt is made by PWA to check the social need for a hospital building. The PWA office does not set itself up as expert in judging such matters and enters into them only when there is some protest or suspicious circumstance in the application.
- 3. Equipment must be bought on bid and specification. Ordinarily the PWA will not interfere with the specifications prepared by a competent architect unless there is complaint that the architect has written the specifications in such a way that equally good equipment is excluded from bidding. Hospital equipment is considered to be of so technical a nature that the PWA does not presume to question the right of experts to decide what is best. Competent architects and administrators usually get the type of equipment they want.
- 4. A considerable additional amount of "paper work" is required. There must be a reasonably complete statement of what is proposed and why it is necessary, accompanied by sketches and estimates which are checked by PWA engineers. Preliminary sketches

are not binding, however, and changes may be made. Reports must be made that under ordinary circumstances would not be required. Federal aid often makes more work also for the owners but not more than good business judgment dictates. Accurate and adequate records must be kept. Lax methods are not tolerated.

5. The wages and hours of workmen are regulated. "Prevailing wages" in the locality, as ascertained by the applicant and approved by PWA, must be paid. There are no minimum prevailing wages for the nation as a whole. Hours may not exceed eight per day or 40 per week.

6. PWA inspectors must pass upon the work as it is constructed. Usually these men are intelligent and reasonable; occasionally they are arbitrary. When arbitrary, they can make it difficult for the contractor, architect and owner.

7. Political influence in the approval of PWA projects has been repeatedly charged. This is difficult to prove or disprove. Architects report, however, that the PWA itself appears to be honestly and competently administered. If there is political interference in giving or withholding the grants or loans in the first place, it apparently does not continue to operate after the loan or grant has been made.

Hospitals that wish to take advantage of PWA aid must submit their applications by Sept. 30, 1938, and be prepared to start work by March 31, 1939. Prompt action, therefore, is essential. If there are not sufficient funds in the new PWA appropriation to permit loans to voluntary hospitals, they may perhaps obtain such loans on similar terms from the RFC.

We Need Money

GIFTS to charities in the United States fell in 1936. Of 19 billion taxable income, only 2.03 per cent went to philanthropy."

Voluntary hospitals have no contract with philanthropy, only a gentleman's agreement. This is one of the weaknesses of the voluntary system and it must be accepted, like many other things in life, because we must reconcile ourselves to weaknesses where there are many elements of strength. Besides, a gift is a gift.

If the opening paragraph, which appeared as a news item, is accurate the contributing public is not keeping faith with the voluntary institutions that it has created. The philanthropist knows in advance, when he enters into the gentleman's agreement, that he will be obliged to make an additional contribution to his favorite charity after he will have finished paying his surtaxes. In actual practice, what proportion of all voluntary contributions to the hospital is made by the philanthropist-trustee himself? The voluntary hospital prides itself on its superior position as pacemaker for all hospitals. This costs money. The implications of such

an ambition must have been known to the philanthropist when he undertook this communal trust.

Ti

allev

drav

tech

adva

B

foug

anti

two

R

tem

is h

botl

who

trar

T

hos

mil

blo

cos

die

ma

the

fit

do

th

C

0

Another motive for reviving this subject is the tendency of some hospital administrators to yield either too much or too little in budgetary matters. It is clearly bad business practice to mortgage the future and spend money which ought to have been contributed but has never been received. Yielding too much in budgetary matters brings headaches that are doubly severe because they are spiritual as well as physical. Yielding too little, on the other hand, only proves that Goldwater was right when he wrote: "A deficit is often the symbol of a noble ambition."

The philanthropic contribution toward the maintenance of the voluntary hospital must be as sure as it is wise and as generous as it is communally wholesome. Otherwise we shall be handicapped in planning for the future while a form of organization for the care of the sick, which is one of the outstanding achievements of civilization, will continue to live in a state of uncertainty and even anxiety.

Is there a way of improving on the terms of the gentleman's agreement? We have no contract with philanthropy.

Summer Begins

INDEPENDENCE DAY and then above the equator—summer. Hot nights and days of pain, wards and rooms that reek with summer discomfort, wilting doctors and nurses, frayed tempers, lowered mental and physical vigor, these are attributes of the average hospital following the summer solstice.

If railroad coaches, stores and amusement houses are made comfortable in summer for the well, how much more important is such provision for the sick! Why this tardiness in the case of the hospital? The answer is purely the difficulty of procuring the necessary funds. To those hospitals that will pioneer in air conditioning private suites, operating rooms and wards will go the patronage of their communities. What finer gift could be made by a public spirited citizen than that of providing a cool climate for those who are ill in summer!

Blood Banks

THE organization of blood banks has taken the fancy of the public as well as of the hospital field. The very name is intriguing. To the public the orderly arrangement of flasks of life-saving blood on the shelves of the hospital refrigerator promises an ever-ready panacea in the event of sudden and devastating illness. But the physician and the surgeon know full well that the collection, preservation and administration of this blood do not constitute the arrival of the medical millennium.

Transfusions are always dramatic, often capable of alleviation and sometimes actually life saving. Withdrawal and injection of blood by means of the refined technic recently developed constitute really important advances in today's medicine.

But scientists inform us that, when infection is being fought, fresh blood is highly advantageous because antibodies disappear from blood preserved more than two or three days.

Replacement of blood lost from the circulatory system is another matter and that preserved for many days is highly useful. Indeed, therapeutic use is found for both the serum and the corpuscles of banked blood when these ingredients are employed separately for transfusions.

The chief advantage of the organization of this new hospital service is one of expediency, of avoiding last minute haste and confusion, of having always on hand blood of the several types for emergency use at lower cost. Recognizing the limitations of blood banking, hospitals would do well to organize such a service. It is efficient and modern but certainly not a cure-all.

Sulphanilamide

ıs

Hardly a year ago the country was shocked by a series of deaths resulting from poisoning with diethylene glycol—a deadly poison in the amounts ingested—that was employed in the preparation of an elixir of sulphanilamide. This catastrophe did not materially lessen the growing use of sulphanilamide in the treatment of streptococcic infections. Certain disorders caused by the colon bacillus, the gonococcus and even the pneumococcus were found to be benefited by this agent.

Abuses of the newly discovered chemical followed, as is always the case under such conditions. Excessive doses were administered and those hypersensitive to this drug were given an amount too great for them. Certain blood destructive states were observed or the generation of the corpuscles themselves was suppressed.

But day by day in the medical literature the story of the conquering of meningitis, peritonitis, pyelitis and gonococcic urethritis cumulates. Hospital executives will do well to follow the advances in chemotherapy of which this foe of the hemolytic streptococcic infections is a fine example.

Bargain-Counter Obstetrics

E XPECTANT mothers often find it profitable to shop around for hospital accommodations. For some reason there seems to be keen competition among the obstetrics departments of general hospitals. Rates often range from a flat charge of \$35 for a ten day stay in a semiprivate bed to \$100 or more for a private room. Some make no charge for nursery days; others

require the payment of from \$1 to \$1.50 for each baby day.

Some hospitals admittedly charge less than cost in the maternity department because many of the patients are young and their husbands have not yet established their earning power. These institutions frankly are subsidizing good obstetrics in their community. They have the money to do it. No one can quarrel with them.

But what about the hospitals that cannot subsidize this department? When one maternity department lowers prices, others often must follow suit. Even good semiprivate service cannot be provided for \$3.50 a day. This is doubly true when a baby as well as his mother must be maintained. Hence, this important department is likely to show a greater financial loss at the end of the year than many hospitals can afford.

A number of institutions have been unable to carry on obstetrical work. Others offer an unsatisfactory service because they are reluctant to close the department but they do not possess adequate nurses and equipment. The rapid advances required by modern obstetric methods make it increasingly difficult to keep this department abreast of the times if it is run on the bargain-counter basis.

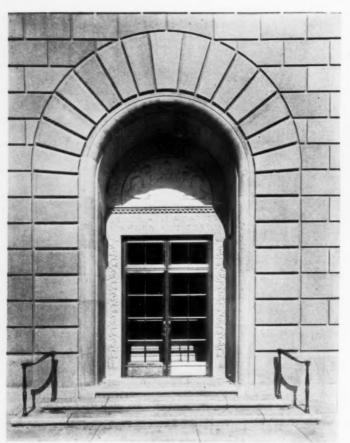
As a result the public is confused as to the cause for such price fixing, is dissatisfied with the care given and often becomes suspicious of the fair dealing of institutions generally. Here is another argument for some attempt at some standardization of hospital services and of rate cards. Hospital councils could well undertake to answer this vexing problem.

Practical Nurse

RGANIZED nursing is endeavoring to provide skilled care for the sick by elevating professional standards and by providing an adequate living wage for the nurse herself. This effort is proper and right. But when, by legal enactments, it endeavors to legislate the practical nurse out of existence, it is guilty of employing questionable methods to protect the sanctity of the degree R.N.

In one state it is made an offense punishable by a fine or imprisonment for any person not a registered nurse to accept a fee for caring for the sick. To reduce this matter to an absurdity, if the widow of a former physician seeks to support herself by caring for her sick neighbor she commits a criminal act.

No doubt the practical nurse needs education and perhaps some type of control to prevent her masquerading as a registered nurse. But this is certain: some practical nurses are rendering a splendid service to the sick and to physicians generally. Organized nursing will do well to shun any rôle that will be interpreted by the public generally as that of the persecutor of others not equipped with a R.N.



Auditorium at

JOHN H. HAYES

meet

tions

vidir

for t

desir

first

site

high

ston

new

colo

surr

sash

seco

with

pers

and

aud

A

T

Af

N A WALL of the entrance lobby of the Max and Flora Einhorn Memorial building, the newest addition to Lenox Hill Hospital in New York City, is a tablet that reads, "This building and its contents donated by Max Einhorn, M.D., in appreciation of the opportunity to serve Lenox Hill Hospital and Dispensary for more than 50 years."

In this short statement is contained the creed of the medical man as we have learned to know it. It might be called an abridged Hippocratic Oath. The wording is that of Dr. Max Einhorn, renowned stomach specialist, who happily is still practicing the profession he has honored and through which he is known throughout the world.

When Doctor Einhorn asked for suggestions for his contribution, he was told that plans for the future included razing a six story tenement adjoining a new wing, which tenement deprived both hospital and nurses' home of considerable light and air. These plans called for a two story auditorium for medical

The view above shows the front entrance in detail. In the lunette are the heads of Boas, Küssmaul and Ewald, with the inscription, "Founders, Pioneers, in Gastro-Enterology." Below is a corner of the roof garden for nurses and at the right is a view of the entrance lobby. Floor and base of the lobby are marble and the walls are paneled in knotted pine below the classic cornice.





Lenox Hill

meetings and for other gatherings.

S

After discussion of many suggestions, Doctor Einhorn, intent on providing the greatest amount of good for the greatest number, expressed a desire to construct the building. He first purchased for the hospital the site and a building on the property.

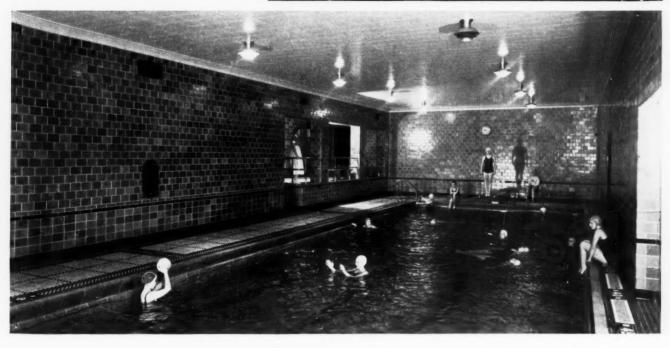
The new building is three stories high, with granite base and limestone front, matching the adjacent new wing. Side walls are a light colored brick, to reflect light into surrounding lower floors. Window sash are of bronze. The first and second floors contain an auditorium, with balcony, seating more than 400 persons, with stage, projection room, and men's and ladies' lounge.

Above the street entrance to the auditorium is a lunette in which.

The auditorium, which seats more than 400, has walls paneled up to 9 feet in a teak veneer. Wards for stomach patients are on the second floor. A tile swimming pool (below) for hospital employes occupies the main part of the basement.







carved in marble, are the heads of Boas, Küssmaul and Ewald. Under them is inscribed: "Founders, Pioneers, in Gastro-Enterology." Thus did the doctor honor three of his predecessors.

The entrance lobby has a marble floor and base and knotted pine

walls. The auditorium is paneled up to 9 feet in teak veneer, the same wood being used for the stage front and proscenium arch. On the stage is a cyclorama of brown material, with front curtains of a maroon and cream flower design. Material of the same pattern drapes the auditorium windows. The ceiling is soundproofed and the auditorium air conditioned by means of an ice cooling system that also dehydrates the air. In view of the rare use of a hospital auditorium in July and August, it was deemed best to avoid installation of expensive refrigerating equipment.

litt

tra

pla

ve

lic

th

og

an

an

ne

so

pl

er

of

m

ei

CO

th

Above the auditorium and connected with the third floor of the adjoining wing are wards for stomach patients, with all necessary equipment, including a laboratory and examining rooms. There are 24 beds: 12 in one room, ten in another, and two in a third room. The donor supplied all beds and other equipment for these wards. The rear, or north, ward room is greater in height than the south room. This additional height is in glass bricks, affording a pleasant light which would not otherwise be possible. On each side of the rear ward is a balcony for the patients. Above this ward, on the roof, is a beautiful roof garden, surrounded with shrubs and with entrance only to the nurses' home

There are a basement and subbasement. In the basement is a hydrotherapy room containing two adult and one children's size tanks for water massage. Each tank has two movable turbines and there is an overhead crane for moving paralytic patients from the stretcher into the tank and vice versa.

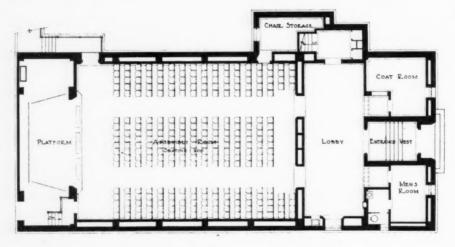
The greater part of the basement area is given over to a tiled swimming pool, 60 by 19 feet, with locker room, observation gallery and showers. This proved a boon to the approximately 1500 workers in the hospital during the hot months of last summer. The water is purified by ozone and the system has been found most satisfactory.

The subbasement contains the water purifying and other machinery.

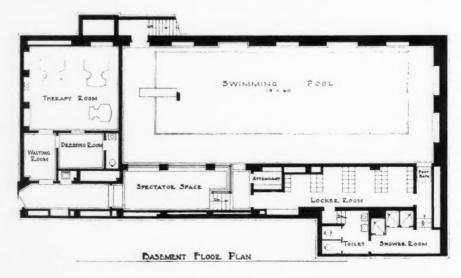
Thus has an eminent doctor provided the medical profession and others a place for meetings and other gatherings; a place and facilities for healing, including therapy for hospital patients; an eye pleasing spot of nature for all, including the neighbors, and a source of health and amusement for those who, with or without compensation, labor in the hospital.



Wards for stomach patients, with examining room, are on the second floor.



First floor plan of auditorium. Architects were York and Sawyer, New York.



Fair Play for Employes

UNTIL recent years employment policies and employe-employer relationships received comparatively little attention from hospital administrators. Religious influences have played an important part in the development of the hospital. The public service and charitable purposes of the institution have always been recognized and emphasized.

Employes were recruited from among those who were motivated by a desire to serve their fellow men and also from those who were in need of homes or who, for one reason or another, could not find employment in industry. There was a marked degree of paternalism toward employes in every institution. This

er

r,

n

paternalism often, however, was not of the most wholesome sort.

Prior to the last quarter century, most hospitals provided living quarters, food, some clothing, in fact, most of the essentials of life to the employe and paid a very low cash compensation. Hours of service were long, duties often were arduous and there was little opportunity for advancement. Under these conditions there were a considerable labor turnover and an interchange between hospital and industrial fields.

Changing Employment Practices

As the number of hospitals increased, the organization became more complex, the demand for employes of all classes, but particularly for those skilled in some vocation, grew larger. As economic and social conditions changed these old practices were no longer effective in obtaining and retaining the personnel necessary to operate the institution. Complete maintenance in the hospital was no longer an inducement.

Consequently, changes were made in employment practices. Employes, for the most part, were no longer domiciled in hospital quarters. While salaries were increased they did not reach, in general, the levels of those paid by industry in comparable positions. Hours of service were being shortened and some improvement ARTHUR C. BACHMEYER, M.D.

was being made in duty schedules when the business depression set in about eight years ago.

Hospitals were seriously affected. Revenues were materially reduced and economies of every nature became imperative. Drastic salary cuts were made and personnel was limited to the smallest number possible. Employment practices reverted in many instances to those of earlier years.

Labor Troubles Begin

In view of this situation and its many implications, it was not illogical that when labor in industry evidenced its dissatisfaction with prevailing conditions hospital employes should also give voice to their desires in a similar manner.

It is reported that in one year's time the membership in the two large labor federations was practically doubled. Such growth can be accomplished only when labor is dissatisfied, when it can be aroused against real or fancied injustice and when organizers can offer something to the individual worker. It then becomes easy to convince him that by joining with his fellow workmen and presenting a united front he can attain his desire for better working conditions.

About two years ago agitation began among hospital employes. There were considerable turmoil, some strikes and a great deal of apprehension on the part of hospital authorities. They were confronted with a new situation, one in which few administrators had had any experience and in which industrialists serving as trustees of hospitals hesitated to advise because their own problems were not clearly defined and because they recognized that hospitals were not entirely comparable to industrial activities.

Conditions of employment in hospitals were carefully studied in a number of cities. With the aid of men experienced in personnel man-

agement and in handling labor problems, policies concerning personnel management were formulated, recommendations as to employment practices were enunciated and in some instances mechanisms through which specific problems could be considered were set up.

The aggressive phase of the situation continued to develop until six or eight months ago. Then because of a change in general economic conditions another period of depression began. There was a marked increase in unemployment. Labor in general realized that it would be impossible to obtain further increases in compensation, shorter hours of work without reduction in pay and other general improvements in working conditions.

Causes for Unrest Remain

Basically, however, the situation remains much as it was before the period of aggression began. The causes that then produced the dissatisfaction and unrest among hospital employes still remain, in many instances. One serious crisis has passed but an improvement in general business conditions with the ever present lag between such betterment and the passing on of its benefits to employes may again produce another crisis. The present apparent calm should not mislead hospital executives into assuming that the storm is entirely over and will not return.

It is imperative that hospital administrators and other executives study the question of personnel relations and do their utmost to improve working conditions, raise the morale of their employes and endeavor to remove those causes of unrest among them that lead to the difficulties which many institutions experienced.

Harold F. Brown* of the industrial management division of the National

^{*}Brown, Harold F., Fears That Destroy Morale, Monthly Letter, National Industrial Conference Board, Inc., Feb. 28, 1938.

HOW TO BE A GOOD BOSS

- 1. Avoid too much interest in self and show interest in the worker an interest in his progress, his health, his home affairs, his hobbies.
- 2. Show appreciation. The worker craves genuine, heartfelt appreciation. It is human nature. It must not be confused with flattery.
- 3. Avoid cynical fault finding. The worker will not tolerate it. It breeds hatred, unrest, contempt and rebellion.
- 4. Make the worker feel that his job is important, that he is more than just a cog in the wheel.
- 5. Avoid argument with the worker. It creates ill feeling. You can always win an argument by avoiding one.
- 6. When you arrive in the morning give the worker a smile and a "Good morning, Bill." It starts the day well. A "Good night" sends him home with a good feeling.
- 7. Provide good working conditions. Give attention to good house-keeping, safety, ventilation, good equipment and supplies. Cultivate the "we" feeling.
- 8. Assign tasks to the worker comparable with his ability and go out of your way to help if he needs help.
- 9. Understand the attitude of the individual worker whether he be radical, indifferent or narrow minded. Be tolerant. Get the facts.
- 10. Recognize ability with promotion and wage increase when the opportunity is available. Make good all promises.
- 11. Eliminate the little job irritants. Keep close to the worker and find out what is on his mind.
- 12. Maintain rigid discipline in the department, but do so by exercising intelligent leadership, not by Simon Legree methods. Be just, be fair, be considerate, be human.*

Industrial Conference Board, Inc., had this to say in relation to the situation in industry.

"Undoubtedly some lessons were learned and progress made. Perhaps the most constructive advance was the more general recognition by industrial management of shortcomings and mistaken assumptions that had contributed to labor unrest, but much remains to be done if management generally would demonstrate to employes that labor's objectives can be more completely and effectively attained by quiet, constructive negotiation with management, with or without the aid of outside organizations, than by their taking the bit in their teeth and going berserk.

"The present breathing spell affords industrial executives an excellent opportunity to review dispassionately events of a year ago, trace effects to causes, search out not only the immediate but the underlying reasons for apparently irrational behavior of employes, and, most important of all, seek with pitiless probing for management's own failures and inaptitudes, often unrealized at the time, but in retrospect holding the answer to much that is incomprehensible."

Administrators and boards of trustees of hospitals are prone to wait until a situation develops before they take action. The same practice has been followed in industry, to which we often look for leadership in matters of management. The present situation, however, calls for positive planning and intelligent action.

Executives should inform themselves as fully as possible concerning modern practices in dealing with employes and should endeavor to understand their problems. This cannot be achieved merely by reading literature and through staff conferences. It is important that employes be encouraged to discuss their problems and needs with their superiors and that these persons get to know their subordinates fully and intimately.

The entire trend of the time is in the direction of better recognition of the needs of the employe for better working conditions. Hospital employes have worked long hours. Split shifts have frequently prolonged the hours they have had to spend in the hospital and away from home. This is a problem that will continue to tax the administrator's resources to the fullest extent. It will also be a difficult one for the institution to solve for it entails increased costs of operation.

of se

izati

conce and

tices

gran

imm

and

is of

in a

has

of t

the

full

cies

hav

mei

and

tion

adju

disc

tha

adn

I

exe

inti

rela

In

ore

in

of

bu

fle

ha

lik

las

tir

D

tu

ha

ev

is

it

be

T

In these days when steadily increasing taxation and declining income from investments are drying up the sources from which flowed a considerable portion of the hospital's income and when earned revenues are declining and operating costs are rising, the financial problems confronting the institution assume gigantic proportions.

Increasing wage rates and shorter hours of work, however, are not the only factors of importance in personnel relations. They take the front rank in the minds of employes when they are agitated by labor problems and are emphasized by professional organizers, but if other conditions of employment are favorable and if management is fair and awake to conditions, much can be done to make employes satisfied with their status in the organization.

Hospitals have grown like Topsy in many respects. Departments have been developed, positions have been created and individuals employed to fill them without due regard to other divisions of the organization, other positions or salary schedules in general. The result often has been a lack of proper balance in the organization. This indicates the need for a careful study of the whole structure of the hospital organizationa job analysis with a careful review and evaluation of every department and position in regard to every other division and position in the institu-

In this manner, a complete pattern will be developed. Each department and each position will be given a proper value and a definite rating. On this basis a schedule of salaries can be developed. This schedule should contain a graduated scale, giving recognition to the qualifications essential for each position and giving also recognition to ability, efficiency, general fitness and length

^{*}Brown, Harold F., Conference Board Service Letter, National Industrial Conference Board, Inc., March 31, 1938.

of service. Such a chart of organization and carefully studied policies concerning employment, promotion and disciplinary or dismissal practices are fundamental in every program of personnel relations.

The effectiveness of the employe's immediate superior as an executive and his attitude toward the employe is one of the most important factors in any personnel program. Industry has found that the foreman is one of the most important elements in the whole situation. If he is not fully informed concerning the policies of the institution, if he does not have the proper attitude toward his men, if he does not understand men and women and their human relations and is unable to make proper adjustments in specific instances of discord, grave difficulties may arise that will tax the abilities of the best administrator.

In the small hospital, the chief executive officer may be able to know intimately each employe, his social relationships and economic problems. In the larger hospital this is not

possible and much must be left to the department head and supervisor.

The accompanying rules of procedure and conduct are excellent ones for everyone in a supervisory position to adopt, whether he is chief executive or minor supervisor. If administrators, department heads and supervisors will develop a proper attitude toward employes and will make them feel that they are important parts of the institution, and if the governing body will adopt reasonable employment policies, hospitals will have little to worry about concerning personnel relations.

Hospital management, like management in other fields, has a definite and attainable goal toward which to strive. It must pay far more attention to its personnel in the future than it has in the past. It is essential that this be done if the staff is to be alert, intelligent and cooperative in every respect and if there is to be developed that peaceful, quiet, confidence inspiring atmosphere that means so much in the successful operation of the hospital.

tion. With the board lie the sinews of war. It controls the moneybags. A common experience is to find the medical staff and the board at loggerheads. The staff thinks the board is tightfisted and ignorant of medical problems; the board has the impression that the staff has no sense of proportion and demands any newfangled contraption whether or not it has been proved. When the two get together, the hospital assumes an important position to both.

It is surprising how easy it is to make these two bodies respect each other. The administrator is the liaison officer and the job is his. An annual dinner given by the board of directors to the medical staff may work wonders. They get to know each other. When this acquaintance has advanced and mellowed, the board rarely refuses any request from the active staff for equipment or additions to the paid help, if the request is at all reasonable and, conversely, the staff does its best to effect economies

The superintendent should make his requests to the board, when possible, as from the staff, and to the staff as from the board.

The board of directors of a voluntary general hospital is composed, as a rule, of lay citizens appointed or elected to the position. In Canada inspected hospitals receive grants from the provincial and municipal governments since they care for indigent as well as pay patients. The large majority of board members have no knowledge of hospital problems when they take their seats. They speak of the care of the sick in general terms. The medical staff and its problems are unknown quantities. An organized staff means nothing. The board of directors understands bookkeeping; economy is a watchword. It is next to impossible to drive home the truth that efficiency of service comes before economy and that a general hospital cannot expect to make a profit.

The primary missionary work rests again with the administrator. He must speak with assurance and with authority. The board of directors must feel that he possesses sound judgment and knowledge; even then, frequent repetition alone will gain understanding.

Developing a Loyal Staff

T. W. WALKER, M.B.

HIGH standards of medical service are obtained by perfect coordination between doctor and nurse in suitable surroundings for the care of the sick.

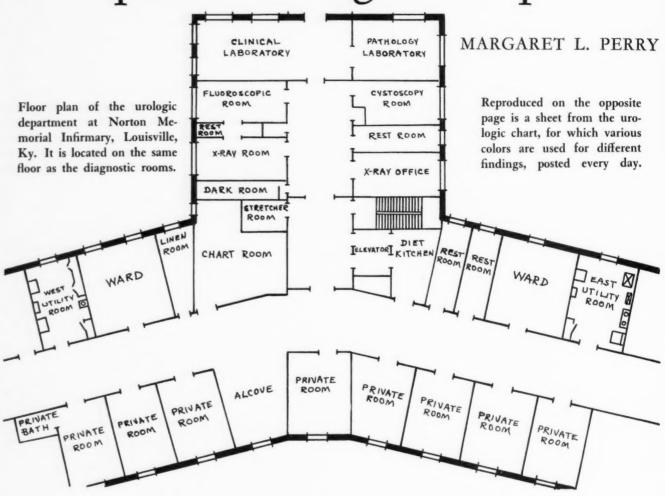
Publicity may breed popularity, but such popularity is likely to be fleeting. Efficiency, on the other hand, begets respect and respect is likely to continue as long as efficiency lasts. A satisfied patient is worth many pages of print. It takes a long time to raise a lowered standard. Damning stories will haunt an institution for years after their causes have been removed. Efficiency in every department of hospital service is demanded and the public expects it to be wrapped in a special brand of kindness and courtesy.

A loyal paid staff is essential to a smoothly running hospital. It must be large enough to do the work. Excessive breakages are often the result of few hands. Delays of service to patients are most irritating and are never forgotten. They are a shortsighted effort to cut down expenses by reducing the nursing staff. The economy effected by such a reduction is false. It empties the private wards. The private ward patient expects service. His friends tell him about "what they do in a good hospital."

The medical staff is the backbone of a hospital. Without its cooperation the administrator's hands are tied. It requires a thorough understanding of the doctor's problems to win his respect and cooperation. Given reasonable equipment and service and an atmosphere of efficiency, the best type of medical men will cooperate. Those of mediocre personal attainments are stimulated to emulate the better trained. Staff conferences bring the men together.

Without the sympathy and support of the board of directors other hospital departments cannot func-

Complete Urologic Setup



ROLOGY has grown to be such an important division of surgical departments that from its position alone it might selfishly demand recognition. Furthermore, any scheme that greatly enhances the prompt handling of patients and makes available more time for their care and comfort helps not only the patients but those who care for them as well. With these ideas in view we have undertaken to outline the plan that has been of much service in our comparatively small hospital.

Most hospitals of 150 beds or more can best be served by one floor or wing devoted to urology. There are many reasons for this. Most urologic work now is concerned with diagnosis and instrumental manipulation. There are many special expensive instruments and forms of apparatus used only in this work and the advantage of the concentration of these

is evident. Their collection in one locality allows them to be kept under lock and key and lessens the likelihood of their being misplaced or lost.

Because these instruments require peculiar care owing to their complicated and delicate construction, it is economical to have them cared for by one nurse who is trained in these special requirements.

The loss occasioned by the immersion of a \$100 cystoscopic lens in a corrosive solution or the dropping of a fragile resectoscope on a tile floor, as will happen all too often in inexperienced hands, will consume the income obtained by many operating room fees. The care and preservation of urethral catheters and rubber goods so that they always are in proper condition and ready for instant service add greatly to the life of these instruments and

also to the convenience of the urologist.

the

the elev nur kee

pro

Th

ant

riv

cor

nii

du

bat

car

tin

the

sib

WI

In the wards and private rooms the patients in preparation for and convalescent from urologic operations require special trays and drainage apparatus not needed for any other type of surgery. Perhaps most important of all, urologic cases demand a special form of care by nurses trained in this type of work and directed by an especially trained supervisor who is able to meet instantly and with unfailing decision the problems of this particular nursing care.

It would be presumptuous to prescribe ours as an ideal arrangement. However, some of the simple conveniences, products of our trial and error, that we shall describe here may be applicable to many hospitals.

One of the important essentials is that this service should be located on

With this intimate contact she can control and arrange her orderly and nursing force so that the manifold duties of caring for irrigations, sitz baths, catheterizations and the like can be interspersed in order to save time.

The fluid intake and the output of urine of practically all urologic patients, both preoperative and post-operative, are carefully measured and a determination of the specific gravity of the urine is made twice daily. For bed patients the output can be measured by caring for drainage bottles at specified prearranged hours.

The intake of fluids is gauged by the regular routine administration of measured quantities as far as possible every hour. Each patient has a special page on the chart on which the intake is noted at the exact time it is given and the total amount is computed for each individual every twelve hours.

Frequent intravenous injections of glucose and saline are the pièce de résistance to most seriously ill urologic patients. Each bed should be equipped with a folding standard for holding these solutions at the proper level. It should be folded out of sight along the length of the bed when the injection is completed. To this standard the jar of solution can be attached instantly. The necessity for carrying portable standards from room to room is obviated and such permanently fixed standards escape accidents occasioned by visitors' feet. These standards also may be used to support decompression apparatus used in the relief of overdistended bladders.

Medication on urologic floors is comparatively simple and uniform. The urinary antiseptics are few in number. Consequently they can be kept on the floor in large quantities. The other drugs are usually of accepted types of antispasmodics, seda-

Date fanuary High Temp. High Pulse		1	2	3	4	5	le	1	8	9
		80	80 884	99	40 d85	98%	98=	84 484	88 88 =	80
SPEC. GRAVITY	A. M.	1.070	1.018	1.018	1.014	1.012	1.018	1.020	1.018	1.02
	P. M.	1.015	1.010	1.012	1.012	1.008	1.012	1.010	1.012	1.013
P. S. P. in hr. periods	Time App.	4 mm.			3	3,				
	1st	30	-	1 60 3	4	3				
	2nd	20	ectomy	0.00	9	,				
	3rd	8.5	عما	Aritone, to	L'iTone,	Mritone, 1				
	4th TOTAL	64.0		2) -	_	-				
ВГООБ	N. P. N.	20							18	
	Urea N.	10								-
	Creatin.	125/	130/	1387	126/	130/	126/	1310/	130/	134
	Pressure	135/85	130/80	138	124/88	130/10	126/88	136/94	130/80	88
	Hemoglo	18 gm.								
	R. B. C.	8,600							4,200,000	
darks:	Janu	ary 10		- Resid					8,000	i

tives and cardiac stimulants, and this simple collection provides all that is necessary in most cases.

Most urologic cases require irrigation in some form. Standard trays that will fit every case can be compactly arranged and stored on the ward, sterile and instantly ready for any use.

The setup of this tray should include two catheters of different size, in sterile covers made of cloth, with one end open so that the catheter can be introduced without touching the hands of the orderly. The tray also should contain a 4 ounce catheter tip glass bulb syringe, a quart jar for solution, an emesis basin to collect the drainage, a graduated glass specimen bottle, a small enamel bowl of green soap, a package of three small sponges, a tube of semiliquid lubricant, a rubber catheter retainer and a stopper. All of this can easily be placed on a porcelain tray, 13 by 9 inches, and covered tightly with a sterile towel. As many of these trays as necessary may be kept on hand.

The solutions used as irrigations may be kept in stock bottles in a warming oven and poured directly into the glass jars as needed. We suggest mason jars because through glass containers the solution can readily be seen and any foreign particle that might accidentally creep in will be instantly detected. Likewise any solution that should be crystal clear, as silver nitrate, easily becomes cloudy and, hence, inefficient and this fact is hard to ascertain in non-transparent vessels.

Special catheters are kept in two ways. Those of the woven silk non-boilable type are sterilized by thorough cleansing inside and out, followed by immersion in oxycyanide and rinsing in sterile water. They are then allowed to dry and are placed in sterile catheter covers with their description and size written on the cloth.

Rubber catheters of the whistle tip and hollow end variety are kept sterilized and in bags marked with their description. Having equipment constantly ready for instant use prevents untold delays on an active urologic floor.

For the use of indwelling catheters, two forms of drain are employed, either a simple form of constant suction or a bedside bottle into which they drain through a rubber tube. No matter what kind of tubing is used, it must be kept pliable and clean. The most satisfactory type is



The sterile irrigation tray is stored on the ward, ready for instant use.

the amber colored ribbed rubber, which does not kink readily. This tubing is semitransparent and permits a view of its contents. We have found it to be much more durable than the ordinary red or black tubing. Its increased initial cost is soon repaid by longer life and inherent advantages.

Charts should be kept in uniform order and preferably with sheets of different colors for different findings. In this way the nurse can instantly find what is wanted. This information is posted every twentyfour hours and enables the surgeon to see at a glance what his patient has done both the day of observation and all the preceding days with all previous laboratory findings, temperature and pulse recordings, intake and output, and any unusual medication, reaction or operative procedures and blood pressure. Changes that may not be insidious when viewed from day to day stand out in relief when glanced at as a whole.

In the cystoscopic room every effort has been made to keep sterile all the instruments, catheters and syringes so that they are ready for the urologist's instant use.

This room is in charge of a nurse selected from the operating room personnel, whose duty it is to care for all the equipment. She is selected from the operating group because she serves as chief urologic nurse in open operations and thus becomes familiar with the steps in diagnosis as well as relief. By correlating that knowledge she becomes more sensi-

tive to the needs of the surgeon at the operating table and is able to anticipate many of his wishes.

The nursing service of urologic patients demands specialized training and unerring watchfulness. Even in the routine cases it is necessary to recognize immediately whether or not a catheter is draining properly, if a suction has developed a leak and a myriad of other details not met with in ordinary surgical cases.

Catheters are obstinate. Sometimes they even seem self-willed in their perversity and if they are not kept in constant draining order the whole effort of the surgeon may be frustrated. In transurethral resections, for example, negligence for an hour may permit a postoperative case a week old to bleed, filling the bladder with clots and entailing sometimes serious and always disagreeable sequelae that could be easily obviated by trained care.

We have organized our nursing service on the urologic floor into three shifts of eight hour duty, each shift in charge of a graduate nurse who has been thoroughly trained in the care of urologic cases. Thus we have someone who knows how to save precious moments every hour of the day or night should occasion arise.

These nurses cannot be chosen haphazardly. They must have a definite liking for urologic cases, willingness to undergo the somewhat arduous special training by the supervisor and the mental caliber and disposition to make them capable in

emergencies. With three good nurses a supervisor need not worry about the capabilities of student nurses, because they are under constant supervision and excellent guidance.

One other advantage of this intensive supervision concerns special duty nurses. In the ordinary small community, it is impossible to train 30 or more nurses in special urologic care. Yet many private patients want three nurses of their own in attendance. A large number of nurses, while able to care for the routine comfort and welfare of their patients excellently, are unfamiliar with the special demands of this type of work. When they have an acknowledged expert at hand to answer any query or to suggest a proper plan, their value is greatly enhanced.

tors

frai

mu

pita

wit

pla

see

ene

thi

let

we

vol

wh

ful

tha

lie

ter

m

re

m

ch

SC

us

u

el

th

n

Skilled supervision on the urologic floor has greatly decreased the demands for special nurses, because patients quickly see that highly trained care is always available. This plan is kind to the patient's pocket-book and releases more special duty nurses for other surgical and medical

Perhaps some persons may think that in this arrangement the nurse has assumed the functions that belong to the intern or the resident. She does not, however, take upon herself the responsibility for medication or treatment in any wise. Rather, we have found that since our nurses understand the routine care of the different types of urologic patients, omissions caused by preoccupation of the surgeon or the resident are readily, almost automatically, supplied. Instead of resenting this assistance there is a congenial feeling prevalent between the medical and nursing staffs because one extra check has been provided.

All of these details, many of which may seem unimportant, have gradually worked themselves into the scheme because we found that they saved time, prompted definite economy, enabled a service to be conducted more efficiently and with a smaller personnel and have made the urologic department a more convenient place in which to work.

The service is improved with the hope of attracting more surgeons specializing in urology to send their patients to our hospital.

Calling All Trustees!

about es, besuper-

nurses

is inpecial small train ologic want n aturses, utine

pe of nowlrany plan, logic de-

cketduty dical hink urse be-

vise. our care pacculent ally,

and ich duthe

a the en-

he ns

r pa-

ighly This

redi-

this ing

nev onon-

eir

lent. pon

AL

tors can get together and discuss frankly and fearlessly their great mutual problem, the voluntary hospital. And it is a problem. Along with other changes that have taken place during recent years, we are seeing our voluntary hospitals threatened. Shall we stand by and watch this take place under our very eyes or, shaking ourselves free from the lethargy that has enveloped us, shall we finally face reality and save this voluntary hospital system of ours? But, first, we should ascertain

C URELY it is a hopeful sign when

hospital trustees and administra-

where we, as individuals, stand on certain matters. To fight successfully, we must have the conviction that our cause is right. Do we believe that the voluntary hospital system has a place in modern life? We must be convinced of its value in representing a private approach to social problems, assuring freedom from political control; its flexibility in making rapid adjustments to social changes, and its contribution to

scientific research.

Hospital trusteeship is not what it used to be, a mere label denoting social distinction, an honor bestowed upon the privileged few. Those seeking such favors might better look elsewhere. Hospitals, like commercial enterprise, have suffered the throes of depression and even today are racked and torn with uncertainty over what the future holds for them. There is place on their boards only for sincere, seriousminded men and women possessed with proper social attitudes who are willing to make the necessary sacrifices in time, interest and money with which to fulfill intelligently the obligations they assume.

The uncertainties of present economic conditions keep the average individual constantly concerned over his own affairs. Has he time to give to his hospital duties? Before answering that question, he should remember that his business involves only himself as an individual, his family and a comparatively small

group. Hospital business, however, involves not only himself and his family, but every man, woman and child in the community. Can he afford to give it merely "what's left" of his busy life?

What are the functions of a trustee? Perhaps it would be well to de-

1. To consider the economic waste of illness and to interpret hospitalization in its relation to the community and to other public health agencies within that community.

2. To establish the general policies of the institution and to accept full responsibility for their enactment, including adequate financing with which to maintain high professional standards.

3. To contribute conscientiously, not in money alone but in time, interest and intelligent understanding; and always to remember that guidance must never be confused with interference.

Suppose we were to take these three principles and apply them as a yardstick to men and women on our hospital boards today. How many would be eliminated? It is something to think about.

Greater selectivity in appointing trustees would be a panacea for many hospital ills. Yet that is not always as simple as it may seem. The answer seems to lie, first, in selecting wisely and, second, in educating intelligently, for without question trustees need education. They know too little about hospital organization. They do not always recognize where

their responsibilities end and those of the administrator begin.

RAYMOND P. SLOAN

This does not mean that the hospital administrator has no need for help and guidance. He does, but if the trustee has not time enough to give to the broader phases of public health work and the part that the hospital must play in it, surely he cannot intrude or it is undesirable that he intrude into details that can be interpreted as administration only. His is essentially the obligation of providing the necessary funds with which to maintain high professional standards and of adopting policies that will achieve those standards.

Much progress has been made, but organization practices are still encountered that have been handed down from the days when an unenlightened board assigned hospital administration to almost anyone who had not been accused of some glaring crime and was in need of a job. Fortunately, it is now recognized as a profession in its own right, and more and more is heard about schools and colleges for hospital administrators. It is unfortunate that the same cannot be said regarding the education of hospital trustees.

Shocking as it may seem, there are still hospitals in which the trustees meet regularly behind closed doors, that is, so far as the superintendent is concerned. Another heritage is the inspection committee. What trustee is qualified to inspect a hospital? And what a reflection upon his own judgment in appointing an administrator who needs to be checked by a

Only through a sound knowledge of their functions and obligations can hospital trustees assure the future of the voluntary hospital system. Here are facts that every man and woman serving on hospital boards should consider with some seriousness

lay group so ignorant of professional details! Certainly there should be groups going through the hospital regularly, but for their own education. They should also go through other hospitals to acquire a basis for comparison and to broaden their knowledge. The appellation "Visiting Committee" would seem to be far more appropriate.

Probably one fault of our trustee setup is that we are overloaded with dead wood; there are present on our boards men and women who never attend meetings and who contribute little if anything in money or personal interest. Better by far a smaller group of vitally interested public-spirited people who will get out and fight than a large number of apathetic incumbents!

Ideal Setup of Board

Twenty or twenty-five trustees should be ample. Let us presuppose a board of, say, 20. As an ideal setup it is comprised of an outstanding lawyer, an engineer, a banker, an advertising man or someone with a knowledge of public relations work - he may even be the owner or editor of the local paper and business men of standing in the community. Women as carefully selected for their interest in public health and social welfare have an equally great contribution to make. Many successful hospitals governed exclusively by women attest to this

In recognition of a changing social order, why not include someone representing labor? Make sure that we are building for the future by including some younger men. Each one should have something to contribute and should realize his obligation to do so. Of paramount importance is it to fit each trustee to his own particular niche.

Certain individuals should be appointed to head special committees, but again let us limit the number of committees. Without any intention of becoming too involved in details at this time, we might suggest a medical committee, nursing committee, social service committee, out-patient committee, finance committee, personnel committee, and, last but not least, a public relations committee. The chairmen of these committees will

form the executive committee, *i.e.* the policy-making group, with the president, vice president, secretary and treasurer. This is merely a suggestive outline from which deviations can be made to meet local needs.

The public relations committee is mentioned last for emphasis. Here is another indication of the changing order of the times. At last hospitals are realizing the need for telling their story and winning the support and interest of the public. It is, in fact, their only hope of survival. Some such committee should be a requisite.

Preferably, its head should be one familiar with the subject. Should there be on the board an advertising man, journalist or publisher, the problem is simplified. Appoint to work with him two or three of the younger business men, for this public relations work is also an excellent medium through which to educate hospital trustees.

Much of the service the layman can and should be rendering the hospital falls under the heading of public relations. Speaking generally, it might be described as interpreting the hospital to the public and winning for it the good will and financial support of the community it serves. Specifically, it means all sorts of projects that will make of every patient and visitor a friend and booster.

Working With Public Schools

The public relations committee, for example, working in conjunction with the administrator or someone on his staff, might well consider the potentialities of a house organ, a little monthly or quarterly news sheet to be distributed to the hospital personnel, trustees, donors and a selected list of names. And don't forget to include the names of high school principals, for there are good reasons for a closer relationship between hospitals and schools. If there is a training school, it is essential; and surely there can be no more effective way by which to educate the public about the hospitals than to begin with the children.

Also, why not include in each bulletin something of interest to the patient upstairs and see that a copy is placed on his bed table? What better opportunity can there be for

telling the hospital story than to the patient who has time on his hands!

Just a word, too, about reports. It is not hard to place hands on hospital reports that have not been changed in general format for fifty years. And what a dramatic story the annual report can tell! Get the public relations committee busy on it. If necessary, retain the services of someone qualified to do the job right.

But should the trustee become involved even in such details as these? A fair question, to which the answer is yes, provided that such details do not intrude into professional procedure. How else is he to acquire hospital background?

sent

liste

tisti

Ho

eral

hos

F

nili

plo

pri

adr

hav

rol

not

wil

or

ma

mi

me

on

ad

fic

T

ce

in

ho

bu

or

Trustees Are Awakening

In such projects, as in all hospital matters, there must be teamwork; the trustees and the administrator must work together always, to ensure the efficient conduct of this business of ours. If the trustee is to become more intelligent on hospital problems, to whom must he look for help and guidance but the superintendent? Despite an understandable reluctance to assume the rôle of guide to those in whose service he is employed, can the hospital administrator of today refuse to accept this responsibility!

There is encouragement in reports anouncing the formation of trustee councils and meetings devoted to trustee problems. At last it appears that the trustee is awakening to the seriousness of the situation and is groping about to find an answer. Too often these occasions are devoted merely to generalities with no attempt to study and to get to the bottom of such basic problems as adverse legislation, unionization of labor, the trend toward a shorter working day and sources of adequate financial support.

Let us form trustee councils, by all means. Let every man, woman and child become as intelligent as possible on hospital matters. This is no time for a defeatist attitude. It is the time to fight, for each and every one to quit feeding his own selfish egotism and to think in broader terms of the community at large, its public health needs and how they can best be met through our voluntary hospitals.*

*Abstract from an address before the Connecticut Hospital Association.

Discharge Practices

in 58 General and Special Hospitals

TO OBTAIN data on discharge practices, a questionnaire was sent to accountants of the institutions listed in the 1936 Financial and Statistical Tabulations of the United Hospital Fund.

There were 37 responses from general hospitals and 21 from special

hospitals.

Forty-four hospitals stated that a nurse, attendant or competent employe escorted ward, semiprivate and private patients to the cashier's office, admission office or to the hospital door. Inasmuch as some hospitals have been more explicit as to their routine than others, statistics could not be equitably cited in connection with procedures.

In the case of private, semiprivate or ward patients, the hospital may

make one of eight moves.

1. The hospital may require on admission one, two or three weeks' payment in advance.

2. It may require payment in full on admission, as for tonsillectomies.

3. It may request that a relative or authorized person take care of the advance payment at the business office if it is not made on admission. This may be arranged by (a) the receptionist or (b) the nurse on visiting days or (c) the patient at the hospital's request.

4. It may request an authorized person to call at the business office if the patient is brought in by am-

bulance.

5. It may send bills to each patient on the day before the money is due.

6. It may send verbal notice to the patient about renewal.

7. It may send a bill to the patient's room.

8. It may mail the bill to the patient.

An overwhelming majority of the hospitals stress their humanitarian policy and emphasize their unwillingness to deal directly with the patient, since his care is their primary consideration. In a number of in-

stances the accountants concede that, with permission of the administrator or of the doctor, the business office will make arrangements with the patient either at the bedside or at the cashier's office in the following circumstances:

1. If no authorized person is available to make arrangements or to obtain information toward that end.

2. If a patient was admitted after cashier's office was closed and no financial arrangements were made, such as for alcoholic cases.

3. If the account is delinquent, as a last resort.

4. If the patient requests it.

5. If the patient has assumed responsibility for his bill and is scheduled to undergo a major operation.

6. If the city investigator finds reported public charges able to pay.

7. If the bill is in dispute because of discrepancy in payment or misunderstanding of charges.

When a balance is due the hospital at the time the patient is ready for discharge, one of the following procedures may be followed:

1. The bill may be sent to the patient's room.

2. An authorized person, of his volition, may visit the business office to settle the account.

3. The nurse may give an authorized person a card, which must be approved by the business office.

4. The nurse may request an authorized person to stop at the business office.

5. If credit is extended, the business office may require the authorized person to arrange for future settlement by note or by other deferred payment plan.

If the hospital bill has or has not been paid, the patient may still be conducted to the business office for one of the following reasons:

HORTENSE M. DILLON

1. To make final disposition of the patient's account.

2. To collect for treatments tardily reported or for treatments given just prior to discharge.

3. To approve for the nurse on the chart the discharge from the financial standpoint.

4. To establish the exact time of the patient's departure.

5. To return valuables.

6. To leave the discharge slip or card.

It seemed to be the consensus that in conducting the patient to the business office or to the door, the hospital has consummated its responsibility from the legal, moral and psychologic standpoints and that, inasmuch as the patient has to be discharged from some point, the business office is the most strategic.

The advantages from the patient's standpoint of settlement at the business office are that he is not upset by financial matters while in his room or embarrassed before other patients or visitors. It is convenient, private, more impersonal and businesslike.

From the hospital standpoint, the advantages are: (1) business and medical matters are kept separate; (2) a smaller clerical force is needed since clerks can take care of routine matters instead of using their time going over the hospital; (3) there is less friction; (4) with less criticism of the hospital, collections are as effective; (5) records, forms and facilities are at hand for any contingency; (6) cash need not be handled on the floors; (7) assurance of patient's physical condition is afforded the administration; (8) the psychologic effect on patient is good; (9) this plan is convenient, and (10) confusion is

Representatives from the cashier's office in three hospitals, not compara-

ble in size, visit the patient on the theory that (1) it avoids embarrassment to the patient; (2) it saves the nurses' time; (3) it prevents wheel chairs and friends of patients from congregating at the cashier's window; (4) charts of discharged patients are delivered more promptly; (5) the room board of vacancies is kept up to the minute; (6) doctors believe it to be the best method of discharge; (7) it is more convenient for patients; (8) it saves the patient's time, and (9) it assures payment of the bill in full.

In a few hospitals the cashier visits the private patients but not ward patients because of convenience to the patient or the cashier's office.

In conclusion the preponderance of evidence seems to point to:

1. The desirability of payment in advance.

2. The handling of financial matters by some authorized person, if one is available.

3. The discharge of the patient from the business office.

4. The escorting of the patient by a nurse or attendant to the business office or to the hospital door.

I should like to add several qualifications, which are my own personal opinions, to the conclusions cited above:

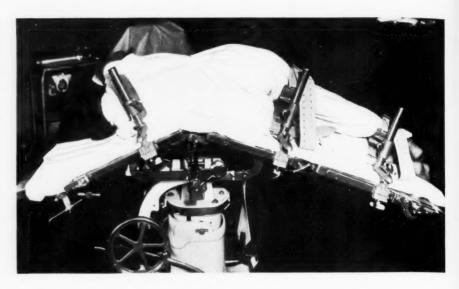
1. The patient should not be approached for settlement with or without the doctor's permission except on his own request because (a) the patient would not be in the hospital if his condition did not warrant admission, and (b) financial obligations from their very nature cause anxiety, detrimental to the patient's recovery.

2. Payments in advance are desirable but (a) funds are not always instantly available for the purpose and (b) dunning for payments at a time of pressing trouble is an obnoxious practice, detrimental to ultimate good will.

3. The business office should provide facilities for privacy.

4. If a balance is due when the patient is ready for discharge, the relatives should be asked for it.

5. The patient should be conducted to the business office only to arrange for settlement or to receive the return of his valuables but never for the purpose of completing or facilitating the clerical detail of the hospital.



Maintaining Nephrectomy Position

MARY VESTA SOURS

MOST surgical supervisors will agree that the placing of a patient in the proper position for an operation is difficult at times.

This responsibility in most operating rooms is the work of the surgical supervisor. She realizes that the position must be comfortable for the patient and that it should avoid unnecessary strain and pressure bindings. She also knows that the position should afford the best and most adequate exposure and that a possible shift of the table during an operative procedure must not let the patient move or slip.

One of the difficult positions to obtain satisfactorily has been the kidney or lateral position when the curved lumbar incision is used. Especially is this position difficult when the operator desires the table broken or when, during the procedure, a greater break is necessary.

We are using with much satisfaction in the University of Kansas Hospitals the Ockerblad kidney rest. It eliminates the need for sand bags and pillows formerly needed to maintain the position.

The apparatus is constructed of light material and is easily assembled. It consists of four parts: back support, two leg clamps and an arm rest.

If the kidney operation is to be done on the right side the back support and two leg clamps are placed on the right side of the table. If a left kidney operation is to be done the order is reversed.

The patient is placed on his side with the back support and leg clamps at his back. It is important to see that the middle space between the crest of the ileum and the costal margin is over the break of the table.

The chest and arm support is placed on the table and adjusted to height and pressure against the thorax (breathing space must be allowed). A small narrow pillow is placed in the arm support and care should be taken to examine brachial plexus for pressure. One arm is extended and rested on the pillow. The other arm is made comfortable. The hands are tied together loosely.

The thigh support is adjusted about an inch from the perineum. The strap should not be pulled tightly. The ankle support is secured in the same way. The bony parts should be padded if necessary to avoid pressure. The apparatus should now be examined and if no binding points are found the patient is ready to be anesthetized by general, spinal or regional anesthesia.

At this time the table is broken to get the necessary exposure. This position is maintained throughout the operation. The apparatus also is used for thoracoplasty, rib resections and suprarenalectomy. Patients in this position while under a local anesthetic complain of no discomfort.

Cleveland's Credit Plan

ORGANIZED as a direct result of the depression, the Hospital Finance Corporation of Cleveland has been in successful operation for four and one-half years. While a child of the depression, it has been so successful that it undoubtedly has achieved a permanent place for itself.

The corporation was not started to collect hospital charges from patients unable to pay or to enforce collection ruthlessly from those able but unwilling to pay. The whole approach of the plan has been rather to obviate the necessity for subsequent legal action, to offer a deferred payment service competently administered, to assist those patients genuinely deserving help and ultimately to change public psychology on hospital obligations in general.

n

he

de

ps

at

of

is

to

ne

)e

is

The need for such a service for the patient, who because of unforeseen circumstances required time to liquidate his hospital obligation, seemed apparent. Every participating hospital had for many years been called upon to extend credit to such individuals. A certain number of patients who reasonably could and should pay for their hospital care over a period of time failed to do so.

Many cases that appeared to be perfectly safe credit risks ultimately would default or require legal proceedings. Often the same individuals would make great efforts to meet obligations for radios or other less necessary commodities. The merchant selling a radio could repossess the merchandise, whereas the hospital could not, and would not if it could. The hospitals wondered if the psychology of dealing with a central credit office would not tend to increase the patient's recognition of his obligation, at least in selected cases.

An added advantage arose from combining the clerical requirements for handling this type of account in one central office. Furthermore, each hospital had seen increasing numbers of its patients borrow money at high interest rates to meet hospital obligations. It was desired to assist such individuals in a manner that would

safeguard the interests of the patient and the doctor as well as of the hospital.

With these objectives, a nonprofit organization was incorporated with nine trustees, at least five of whom must be administrators of member hospitals. It was intended that the other four should be hospital trustees or prominent citizens conversant with the needs of hospitals.

The corporation was sponsored by seven Cleveland hospitals. A man-

The Hospital Finance Corporation of Cleveland was formed in 1933 for the cooperative collection of old accounts. The assistant director of the University Hospitals gives a history of its operation

ager and secretary were employed to operate the offices of the corporation, located in a downtown building. The participating hospitals agreed to underwrite a six months' budget, allocated according to each hospital's inpatient earnings.

It was hoped that the income represented by interest charges on accounts financed ultimately would cover the operating cost. Six per cent interest on the total amount of the patient's obligation was expected. There is little justification for criticism of this rate in view of the fact that it is considerably lower than rates charged by commercial financing houses.

It was recognized that a rotating cash fund, with which to advance money to the hospital at the time the service was rendered, undoubtedly would stimulate a much greater usage of the service. After considerE. L. HARMON, M.D.

able discussion it did not seem possible to provide such a rotating fund. It was therefore planned to go ahead with the service and pay hospitals as the accounts were collected.

Before starting the service, letters were sent to the attending staff members of each participating institution explaining in some detail the purpose of the corporation. It was pointed out that the plan was not designed to enable the hospital to take care of patients totally without resources but was designed to make hospital service more readily available to the individual who could not pay his account in advance and to safeguard the interests of the hospital while reducing the expense incident to the collection of unpaid accounts.

Consideration was given to including, when requested, the private physicians' or surgeons' fees. It was felt inadvisable to attempt such a step unless a specific request for the inclusion of this service should be forthcoming from the practicing profession. Consequently, no mention of this was made in the letter.

The physician was informed that any patient unable to finance needed care except on a deferred payment basis, when referred either to the hospital admitting office or to the offices of the corporation, would be asked to execute an application for credit in an amount not to exceed the anticipated total cost of the type of service required. On this credit application the patient would agree to execute a promissory note to the corporation, payable according to the terms specified in the note, and further to obtain the signatures of two responsible persons as security, or such other security as the corporation might deem acceptable.

He also was informed that through the central office of the corporation a credit investigation would be made and the hospital then would be authorized to extend such credit if the case was an acceptable risk. He was told that there would be an interest charge of 6 per cent on the total obligation.

For emergency cases credit arrangements would be made after the patient's admission, through the admitting officer and some responsible member of the family.

He was asked in nonemergency cases to have suitable patients either approach the hospital admitting office or the corporation offices directly to make the proper arrangements.

The plan accordingly was started June 1, 1933. The admitting officers and collection officers of the individual hospitals were made representatives of the corporation and were provided with the necessary forms. In general, it was believed that it would be more successful, when time permitted, for the patient to make his own arrangements at the central offices since greater stress would thus be laid on the desired psychologic element.

The admitting officers were instructed that this plan should not prevent asking the patient to pay cash. All free and industrial injury cases were considered outside the scope of this service.

The forms provided consisted of a credit application suitably drawn to protect the hospital's interests and an information blank and credit acceptance form, specifying the anticipated maximum amount of the obligation and setting forth the patient's financial information. A third form, authorizing the hospital to extend credit to the patient in the amount asked, was provided. Investigations include a checkup through the retail credit bureau, the files of the collection department of the Cleveland Hospital Council and on selected cases, the central investigation service of the hospital council.

Each of the member hospitals gave the corporation power of attorney to represent its interests in the collection of accounts due.

Admitting officers were instructed on the general plan of operation and meetings of the admitting officers were held from time to time to discuss problems.

At the end of the first six months, it was apparent that without increased usage the service would not be self-sustaining. A modified plan

was, therefore, evolved whereby an annual membership fee of 25 cents per bed was charged each member hospital. This charge, plus the interest collected, was to be applied against the total operating budget. Any deficit encountered divided by the total number of cases handled during the six month period gave a service charge per case. Each hospital would then pay this service charge for its total number of cases handled during the period. Thus the cost per case would decrease as the total volume of cases increased.

From a study of the accompanying tabulation, there is apparent a steady growth of the service. Instead of the original seven member hospitals there are now twelve, all except two of the hospitals of Greater Cleveland that would be eligible for membership. During the earlier years one of the original member hospitals withdrew from the plan, but within a year was reinstated. In at least some instances pressure of patients has, in part, been responsible for nonmember hospitals obtaining membership.

Conservative Publicity

Little effort has been made to publicize the service, except through keeping the individual hospitals and their staff physicians informed by periodic communications. This method and requests by patients have been the most satisfactory means of extending its usage. Dignified folders outlining the plan, suitable for distribution to patients, are available to staff physicians. They also are used in the hospital admitting offices.

Advertising in the monthly publications of the local medical society was abandoned after a brief period as not particularly productive of results and as objectionable to some of the member hospitals.

Both number and volume of accounts financed are now nearly three and one-half times that of the first six month period of operation.

Considerable variation in methods has been used in an effort to meet the wishes of the individual hospital. For example, in the earlier days of the plan some of the hospitals attempted to handle the details of financing through their own admitting officers acting as agents for the corporation. All hospital authorities

have concluded that more satisfactory handling occurs and the patient responds better to his obligation when he has been sent directly to the organization offices.

In some instances hospitals, recognizing a case in which they would in all probability be rendering free service to the patient anyway, have requested handling such accounts through this service, in the hope of realizing something on the account. Such efforts have been discouraged by the corporation and results have been naturally disappointing.

6-1-

2nd 3rd

4th

1-1-

6th

dis

acc

des

hos

tra

rer

Th

wi

val

sar

rep

COI

lec

qu

for

ha

op

cer

res

co

fo

pe

ha

pe

of

ou

T

ab

One hospital at present, because of certain unusual conditions, finances all accounts in which full cash settlement does not occur at the time of discharge without the corporation offices having the opportunity of passing judgment on the acceptability of the account. This tends to build up volume and increase collection losses when the results are compared with other hospitals in which more selection is made. Even so, the hospital in question believes the service is useful in meeting its needs.

Study of the amounts collected shows the same continuing growth as the volume and value of accounts financed. There is apparent for each period of operation a lag between the amount financed and the total collections. This is to be expected because of the continuing growth of the service and the varying time commitments in individual notes.

The build-up of financed accounts always will be from six to twelve months ahead of the payment time expectancy on the same accounts, until a period is reached when the volume of accounts becomes stable.

Collections by Attorneys

Year	Amount			
1934	\$ 338.99			
1935	1,379.30			
1936	3,867.89			
1937	5,377.60			
Total	\$10,963.78			

The total collections by attorneys represent only 2.8 per cent of the total amounts financed during the entire period of operation. Unfortunately, no accurate records have been kept for the entire period to give detailed information as to ultimate

Tabulation Showing Growth and Results of Finance Corporation Service

	Number Hospitals Participating	Number Accounts Financed	$Total \ Amount \ Financed$	$A mounts \ Collected^1$	Interest Collected	$Expense\ Budget$	Income From Membership Fees	Service Cost per Case
1st 6 mo. 6-1-33	. 7	222	\$20,531.19	\$ 4,674.61	\$ 91.66	\$ 2,963.502		
2nd 6 mo. 3rd 6 mo.	. { 7	333 292	27,665.14 23,893.93	$10,\!383.89 \\ 14,\!545.62$	555.94 517.64	2,256.72 $2,353.97$	\$ 482.50 492.25	\$3.66 4.23
4th 6 mo. 5th 7 mo. 1-1-36	$egin{array}{ccc} 8 \\ 9 \end{array}$	$\begin{array}{c} 316 \\ 558 \end{array}$	24,086.97 37,059.53	$15,407.34 \\ 23,685.21$	$\begin{array}{c} 667.42 \\ 1,033.20 \end{array}$	2,405.63 2,991.71	529.13 599.50	2.93 1.88
6th 6 mo. 7th 6 mo.	$\left\{\begin{array}{c} 10 \\ 10 \end{array}\right.$	$\begin{array}{c} 685 \\ 644 \end{array}$	59,263.60 53,212.64	30,384.18 $36,753.53$	$\substack{1,998.52\\2,160.78}$	2,685.76 $2,754.02$	$629.50 \\ 629.50$.085
8th 6 mo. 1937	$-\left\{egin{array}{c} 12 \\ 12 \end{array} ight.$	778 790	66,857.29 $69,955.35$	40,963.58 $43,613.19$	2,288.84 2,675.17	3,093.78 $3,418.05$	657.37 717.00	.19 .035
TOTALS-55 mos	. 12	4618	\$382,525.64	\$220,411.15	\$11,989.18	\$24,923.14	\$ 4,736.75	

¹This amount includes collections by attorneys.

²Includes nonrecurring item of \$440 for furniture and equipment.

disposition of the difficult or dubious accounts. Such accounts have, of course, been accepted and their final destiny is always in the hands of the hospital concerned.

reen or-

ld ee ve its

ed ve

of

of

n

of

d

d

e

In 1937 there were 290 accounts transferred to attorneys for collection, representing a total value of \$17,085. These figures cannot be compared with those representing number and value of accounts financed for the same period, as most of the accounts represent obligations incurred prior to 1937.

A more complete analysis of accounts outstanding and an exact collection efficiency figure are out of the question because of the limited office force with which the organization has been provided.

For the whole 55 month period of operation, the expense totals 11.3 per cent of the amount collected. For 1937, however, the expense item represents only 7.6 per cent of the total collections. This figure was 18.5 per cent for 1934, the first full year of operation. In other words, over a four year period there has been a 10.9 per cent reduction in the costs of handling these accounts, resulting largely from increased business.

The membership fee of 25 cents per bed seems justified in recognition of certain intangible benefits accruing to members. This point may well be illustrated by a specific case.

A patient, under observation in the out-patient department, previously had been cared for as a private patient by one of the better surgeons. The surgeon had referred the patient to the out-patient department as unable to afford further private care and an investigation confirmed his

judgment. At this time the patient owed the hospital \$400 for his previous private care. All collection efforts had been futile. In the surgical clinic it was decided that further major operative procedures on the patient's stomach were imperative and he was referred into the hospital.

At this juncture the patient's family demanded that the case be returned to the hands of the original surgeon as a private patient for the surgical operation. They were informed that such a transfer would scarcely be possible in view of their financial difficulties and their \$400 debt to the hospital of two years' standing.

Not satisfied, the family demanded to see the administrator who reaffirmed the statements of the admitting officer. He was then asked if there was any way by which transfer to private care could be accomplished. The answer was, only by payment of the old account, the charges already incurred for ward care and a week's advance payment for the private service accommodation, plus satisfactory arrangements with the private surgeon in question.

The patient's representative inquired whether any time payment method might be used. With a supposedly reliable knowledge of the patient's circumstances, the administrator attempted without success to discourage the transfer as being beyond the means of the family.

Finally the hospital finance corporation was suggested and the family was told that if they could obtain acceptance of their total obligation by that organization the transfer would be permitted. The family left, supposedly to go to the corporation.

Early the next morning the admitting officer startled the administrator by informing him that the family was back with cash to cover all the stipulated requirements in an amount in excess of \$500. Questioned, they were evasive, but stated that they had not been to the Hospital Finance Corporation. The transfer was effected and the hospital profited by a considerable sum on an account that did not even reach the Finance Corporation.

In other similar experiences, the corporation was a protection without its services actually being called into play.

As income to the corporation has increased from both interest and membership fees, the cost per case has steadily and rapidly diminished until for the last six months of 1936 there was no service charge. At that time the volume of work had increased to such an extent that additions to the budget were necessary. As a result the service charge increased in the first half of 1937 and then dropped to the almost negligible amount of $3\frac{1}{2}$ cents during the last half of the year.

This method of meeting operating costs has seemed fair and satisfactory to the hospital membership.

Those of us in Cleveland who have been close to the work believe the corporation now has achieved an established and permanent place for itself in the hospital picture. The usage and growth of the organization have exceeded the hopes and expectations of those who sponsored its original development. We predict a secure but unspectacular future.

Landlord to Physicians

GEORGE D. SHEATS

HOSPITALS located in less congested areas can well consider the advantages of absorbing the physicians who are following the trend away from downtown office accom-

modations by providing office space within or adjacent to the hospital.

A hospital may unify its scientific apparatus so that its staff may employ it in diagnostic study at least

possible expense. No other agency in the field of medicine is so well adapted and equipped to lend itself to such a plan. Such a service, when offered in the proper manner, has untold advantages both to institution and staff members. This is especially true of staff members not connected with clinics or groups. The hospital's facilities enable them to conduct their studies without losing contact with their patients.

Such an arrangement has been in operation in the Baptist Memorial Hospital, Memphis, Tenn., since 1928. The success of this venture is no longer questioned. After this plan had been in operation for ten years, there was not a single dissatisfied physician when all of the original lessees were queried recently. They are unanimous in their appreciation of the convenience.

This pavilion of physicians' offices originally had eighteen tenants. At the present time there are 68 physicians and three dentists occupying offices. The arrangement has been so satisfactory, both to the physician and to the hospital, that a new five story addition, 13,671 square feet in area, is now under construction. Also under construction is a 100 bed addition to the hospital which will take care of the increased demand for beds.

The first building was planned to include all conveniences that might add to its attractiveness and contribute to the convenience of the attending physicians and the hospital. More than 60 hotel rooms are located on the top floors; these are used for the convenience of physicians hospitalizing patients from a distance, who are unable to return to their homes the same night.

Ambulatory patients who are receiving treatment in any one of the tenants' offices, discharged hospital patients who are in no condition to return to their homes and relatives



54

The MODERN HOSPITAL

mod unit one com class O room nish basa are pita

vide

C

whi

of h

pha at a mos mec A valu kep T grad duty four tive their thei

office This ular tena T espessaviare builthos

the

L

the

ryir

esp of phy ma tors

the Ting

of hospital patients also are accommodated in these rooms. This hotel unit is not open to the public and no one is permitted to register unless he comes under one of the foregoing classifications.

S

On one of the hotel floors four rooms have been set aside and furnished with electro-cardiographs and basal metabolism apparatus. They are under the direction of the hospital laboratory technicians who provide these services to ambulatory patients.

On the ground floor is a pharmacy which is open to the public. The pharmacy recently has been enlarged at a cost of \$15,000 and is one of the most complete in the city. No "patent medicine" is recommended or sold. A complete stock of biologicals, valued at approximately \$5000, is kept on hand at all times.

This department is staffed by five graduate pharmacists who are on duty or on call during the twenty-four hours of the day. It does an active business among the doctors in the building, who order supplies for their office practice. The bulk of the pharmacy's patronage, however, comes from visitors to the hospital, convalescent patients and hospital personnel.

Located also on this first floor is the surgical supply department, carrying a complete line of instruments, office furniture and office supplies. This department is exceedingly popular and a great convenience to the tenants.

The physicians in this building are especially appreciative of the large saving of their time since the offices are located in a wing of the same building in which their patients are hospitalized. They say, and rightly, that it is no longer necessary for them to lose time in visiting various hospitals. They now attempt to have all their patients use this hospital.

From the patients' standpoint this arrangement cannot be improved, especially in obstetrics cases and cases of critical illness, as their attending physicians are virtually at their command during office hours. These factors naturally have increased the bed occupancy of the hospital and made the service more efficient.

The net revenue from this building, including commercial enter-

The pharmacy (top) is one of the most complete in the city and has a staff of five graduate pharmacists. Elevators are conveniently located for physicians and patients.

prises, will average \$100,000 a year or a total of \$1,000,000 for the ten year period.

This additional income enables the hospital, even though without large endowment funds, to carry on its scientific program without charging

this special research to operating expense.

There are many angles to be considered before any hospital should attempt such a scheme. The local situation, both from an economic and a professional standpoint, has a definite bearing on the success of such an enterprise. In our case, it has been beneficial and satisfactory from every angle.

Future of the Anesthetist

THE anesthetist is one of a large group of hospital employees, all of whom must work together for the common purpose of promoting an efficient organization, so that the patient not only will receive the best type of service, but will receive it pleasantly and cheerfully.*

The hospital constitutes the chief field of the nurse anesthetist. Those who work in offices, particularly in dental offices, have a multiplicity of duties of which anesthesia is only a minor one. There are nearly 7000 hospitals in the United States potentially in need of a nurse anesthetist. The vast majority of these are less than 100 beds, and while large hospitals may each have several anesthetists, the vast opportunities for the nurse anesthetist are in the small institutions.

In the great majority of these, the anesthetist cannot be economically employed if she does only anesthesia. She must therefore be willing to combine other duties with anesthesia. This certainly is not beneath anyone's dignity. If she is willing to do this, there are thousands of opportunities.

Service Is Improved

It is the obligation of the anesthetists' organizations to encourage this kind of work, since the field for anesthesia service is thereby greatly enlarged, the general quality of anesthesia service in a small community is generally improved and the standing of the nurse anesthetists will be made more secure.

If the nurse anesthetist refuses to do other work that can be correlated with her work as anesthetist, or fails to do it cheerfully, the smaller institutions that cannot afford to hire an anesthetist on a strictly full-time basis will not be open to her.

In hospitals of modest size, the department of anesthesia probably will be in charge of a staff physician who has had some training in anesthesia, but who is not a trained anesthetist. Here the nurse anesthetist is in a position to be of great service to the staff, the hospital and indirectly to the public. If the anesthesia is consistently good, the position of the nurse anesthetist will be secure, because the hospital needs an anesthetist in residence who will be kept busy in her chosen field of work. The convenience to the staff and to the hospital and the saving of money to the community will be such as to solidify her position.

However, if the anesthesia is consistently poor, the hospital and staff probably will remove the nurse anesthetist from the picture entirely and will arrange for the services of a physician anesthetist. In this situation the quality of anesthesia service will be excellent, but with the physician not being resident, the situation will be inconvenient and, in addition, the anesthesia service will be more expensive to hospital and patient.

In many large hospitals, medical anesthetists will take complete charge of the department. This is properly so, as there is work to produce sufficient income to justify the service of a medically trained anesthetist. There also will be sufficient material and a proper diversity to stimulate the medical man to develop himself in anesthesia and to afford research and improvement in the science of anesthesia. These hospitals also will be the training centers of the nurse anesthetist.

Many of these large hospitals have, and will continue to have, nurse anesthetists.

They will continue to employ them for many of the operations and a majority of deliveries. Since these hospitals are training centers, as well as medical centers for the developing of anesthesia, the nurse anesthetist must be particularly capable, must keep abreast of the times, must be acquainted with the newer anesthesia methods and materials.

Associated with the questions of what hospitals expect of the anesthe-

tist can properly be considered the obligations of the national and state nurse anesthetist associations from the standpoint of hospitals. In the first place, these associations should stimulate the larger hospitals in maintaining centers for the training of anesthetists.

There is a shortage of nurse anesthetists today as there is a shortage of nurses. While this temporarily may have a tendency to raise salaries, it is a short-sighted policy that would restrict the number of those taking special training in order to raise salaries, because the inevitable result of such a policy would be to remove for all time the nurse anesthetists from many hospitals who would feel that they are justified in retaining a physician anesthetist.

Advantages of the Nurse

There is competition between physician and nurse anesthetists. It is doubtful whether physicians generally will choose the nurse anesthetist instead of the physician anesthetist if both are specialized in the field. The peculiar advantage of the nurse anesthetist is that since the matter of her training is much less costly than that of the physician anesthetist, and since she is generally in a position to live at the hospital, her services can be obtained at much less cost and she is available for service more promptly.

Anesthetists' associations should do everything possible to improve the quality of anesthesia given by nurses. There should be standards set as to the type of individual who may take special courses in anesthesia. The curriculum itself should receive careful and continued consideration. Anesthetists who have finished their courses should be encouraged to associate themselves with anesthetists' organizations for the stimulation and improvement that contacts can bring.

The whole future of the nurse anesthetist is dependent upon the ability of members of that group to keep their feet on the ground and be practical, and at the same time to see to it that the quality of anesthesia given is the highest.

MELVIN L. SUTLEY

^{*}Presented at the fifth annual meeting of the National Association of Nurse Anesthetists, Atlantic City, N. J.

Hospitals Provide Medical Care

MICHAEL M. DAVIS, Ph.D.

ASK the man in the street, "Why do you go to a hospital?" He will answer, "To get medical care in serious sickness," or words to that effect. In common parlance, medical care is the purpose of a hospital.

the

state

rom the

ould

in

an-

ort-

npo-

raise

olicy

r of

rder

able

e to

an-

who

d in

ohy-

t is

ner-

etist

st if

The

han

and

n to

can she

otly.

do l

the

rses.

s to

ake

cur-

eful

nes-

heir

ists'

and

ing.

urse

the

o to

and

e to

esia

TAL

More exactly, a hospital may be defined as an institution that provides or organizes medical care, including the services of physicians, for sick persons resident therein. Physicians, whether paid or unpaid, practice medicine in the hospital under their *individual* licenses to practice but as *part* of the hospital organization. A hospital does not, cannot practice medicine.

Within the last half century, an unparalleled advance in the medical and the economic significance of the hospital has taken place. An extensive and complex assemblage of professions and vocations concerned with the sick has developed within the hospital.

This complexity would have led to confusion if careful and elaborate organization of the professional and other personnel had not been developed also. The American College of Surgeons, the American Medical Association and the American Hospital Association have worked with a generation of leading physicians and administrators to create and improve professional staff organization. The physicians of a modern hospital staff do not act merely as individuals. They are organized so as to

work in coordination with one an-

other and with hospital personnel. What does this organization demand of the physician? Every physician who cares for patients in a hospital, whether private or staff patients, does so by virtue of appointment by its governing body, whether voluntary or government. Whether these physicians are compensated or not, they accept, when appointed to a hospital staff, certain obligations to the hospital and to their fellow staff members in accordance with those standards of hospital organization required for approval.

Contrary to belief of the A. M. A., hospital service and medical service cannot be separated, for each is part of the other

Among these obligations is the responsibility of keeping certain types of professional records on all hospital cases, of participating in staff conferences concerning cases for mutual consultation and criticism and of performing operations and other professional procedures only under certain agreed conditions.

The hospital thus organizes the professional service and the physician accepts these obligations when he becomes a part of the hospital organization, without in any way diminishing his rights, privileges or obligations under his individual license to practice issued by the state.

In an article published in The Modern Hospital in July 1936, I asked certain pertinent questions:

"At what point can a line be drawn, if anywhere, between 'hospital' service and 'medical' service? Care of the patient is the central purpose of the hospital. Can a line be drawn across this service, separating it into two elements? If so, at what point should the line begin? Is the service of the nurse, for example, 'hospital' care or 'medical' care? Does the answer depend on the kind of work the nurse does? In some hospitals the nurse will perform certain services which in others are performed by an attending physician or an intern. Does the answer depend on whether the nurse is paid by the hospital or, as in the case of a special nurse, by the patient directly? Is the work of an intern 'hospital' service or 'medical' service? How shall the major operative work of a salaried resident of four years' standing be classified?

"It is obvious that there are functions like heating the building and filing records which are mere subsidiaries to the care of the patient, as contrasted with a surgical operation or an enema, which are that care itself. Are the two former always 'hospital' service and are the two latter always 'medical' service, no matter by whom performed? Is the provision of food a 'hospital' service? Is it the same in the case of a patient receiving regular house diet as in a case of diabetes in which especially prescribed food is an essential part of the treatment?

"In a proprietary hospital owned and conducted by a few physicians, where can a line be drawn separating 'hospital' from 'medical' service? Have the physician-owners or staffs of such hospitals ever tried to draw such a line as affecting their residents or their roentgenologists? And if the institutions are reorganized on a nonprofit basis with the same personnel under a lay board of trustees, do 'hospital' and 'medical' service for similar patients by the same people then become separable in a new way?

"If a patient pays the hospital a ward rate when the physician is paid nothing, should a wedge separating 'hospital' service from 'medical' service be driven in and, if so, at what point? Is a basal metabolism test for such a patient the one or the other? Is the examination of a tissue specimen by a pathologist or of an x-ray film by a roentgenologist, the one or the other? And if the patient paid a special fee for the examination, would it affect the classification? Is an intravenous injection 'hospital' service if given by an intern (or a nurse) to a ward patient? Does it become 'medical' service if given by an attending physician to a private patient?"

In summary: Is the issue between "hospital" service and "medical" service to be raised because of the

nature of the service that is furnished the patient or because of a difference in the economic relation of the physician to the service?

The existing facts of hospital service and organization in the United States at the present time illustrate the unification of the physician's services with the hospital. There are about 6100 hospitals in the United States on the registered list of the American Medical Association, with approximately 1,100,000 beds. These hospitals fall into four broad groups:

1. Where the services furnished patients are supplied entirely by sal-

aried personnel.

2. Where the services furnished patients are supplied by physicians who are independent private practitioners1 having a contractual relation with the hospital but receiving no direct financial compensation from it, other persons serving patients being on full-time salary.

3. Where the organization is a combination of type 1 and type 2, i.e. when some of the staff physicians receive no salary while others do.

4. Where the hospitals are owned and operated by a physician or a partnership of physicians.

Four Types of Hospitals

A study of the hospitals of the country shows that these four types of organization exist in the follow-

ing proportions:

Into class 1 fall nearly two-thirds of all of the 1,100,000 hospital beds and, among these, approximately 21 per cent of all the general hospital beds. Both voluntary and government beds are included in this group, and those serving paying as well as nonpaying patients.

Into class 2 fall about one-sixth of the total hospital beds and 38 per cent of the beds in general hospitals.

Into class 3 fall about one-sixth of the total hospital beds and 41 per cent of the beds in general hospitals.

Into class 4 fall less than 5 per cent

of all hospital beds.

In summary, the services for a large majority of the hospital beds in the United States are so organized as to be furnished by physicians whose financial and professional interests are identified fully with that of the hospital organization since they are on full-time salary.

Taking the general hospitals alone, this is the situation for more than one-fifth of the beds, and a salary arrangement covering part of the physicians exists for another two-fifths of the general hospital beds. Are not "hospital service" and "medical service" unified under these conditions?

Acceptance of a full-time or parttime salaried position by a physician does not affect his legal status. The salaried physician retains all of the rights and obligations that he possesses under his license to practice. The development of full-time and part-time salaried positions for physicians in hospitals has increased during the last twenty years concomitantly with the maintenance of individual licensure of physicians under state law and with the advancement of the standards of medical education and of licensure.

The obligations imposed on a member of a hospital staff, whether salaried or unsalaried, are particularly significant in those types of work that furnish diagnostic or consultative aid to other physicians. The laboratory and the x-ray services are two instances. It is largely for this reason that the laboratory and the x-ray services are conducted by physicians who are directly compensated by the hospital in most instances.

For only a small proportion of the hospital beds in the United States are the laboratory and x-ray services furnished by physicians who work in the hospital as independent private practitioners of these specialties. The latter situation exists in only three of the approved hospitals of Philadelphia and in none of 64 leading hospitals in New York City.

In the United States as a whole, a report² by the council on professional practice of the American Hospital Association showed that 56 per cent of the hospitals of 100 beds and more engage their x-ray physicians on a salary basis and that in nearly all of the remainder by a percentage of the x-ray department's income.

According to the painstaking studies of the Committee on the Costs of Medical Care, there were in 1929 approximately 10,000 full-

²Published in Hospitals, Nov. 1937, p. 50.

time salaried physicians in the hospitals of the United States, excluding residents and interns.

According to the recent studies3 of Dr. H. G. Weiskotten, dean of the college of medicine of Syracuse University, 21 per cent of all of the 14,200 physicians graduated between 1915 and 1930 occupied full-time salaried positions in 1936, and about half, or over 7000 of these, held their salaried positions in hospitals or in clinics associated with hospitals. Furthermore, there are about 7000 interns and more than 3000 residents in the hospitals in the United States receiving their maintenance and, in a majority of instances, some financial compensation from the hospitals. The full-time salaried positions for physicians in hospitals have increased steadily during the last twenty years, as shown by Dean Weiskotten.

of

ex

110

la

ac

in

in

CO

ar

is

th

be

st

al

ar

m

be

th

or

A

Service to Humanity

Present hospital standards of professional and administrative organization have been laboriously won and represent distinctive cooperation between physicians and other publicspirited citizens in a common service to science and to humanity. The development of hospitals in this country has been in the direction of a unified service to the patient, a greater responsibility for the hospital and at the same time a higher status for the members of hospital staffs.

The issue between "medical" service and "hospital" service has arisen with reference to that minority of hospital patients who are private patients, that is, those whose physicians are remunerated by fees received directly from the patients. This issue clearly arises for economic and not for professional reasons.

Such a separation as is proposed between "hospital" service and "medical" service is artificial, is inconsistent with present facts of hospital practice, would subvert the trends in hospital organization fostered by our leading medical and hospital associations, would lower the standard of service and would increase costs to all patients. Hospital service and medical service cannot be separated for each is part of the other.

¹Interns and residents are not considered in any of these classifications except as specified below. Administrative officers are also excluded.

^{3&}quot;Trends in Medical Practice," published in Journal of the Association of American Medical Colleges, Vol. XII, Sept. 1937, pp. 321-356.

Interns in Tune

EMANUEL GIDDINGS, M.D.

THE intern staff comes right out of medical school into an entirely new environment, with little or no knowledge of what is expected of it. Someone in the hospital must explain to these men their obligations, orient them as to the physical layout of the hospital and acquaint them with those with whom they will be associated.

OS-

es³

of use

he

en

al-

out

eir

in

ur-

in-

nts

tes

n a

ial

ıls.

or

ed

rs,

ro-

n-

on

on

ic-

ce

he

nis

of

a

tal

us

Ŧs.

V-

en

of

te

si-

re-

ts.

ic

ed

d-

st-

al

in

ur

0-

rd

ts

ıd

ed

L

Since they report for duty to the administrator's office, it devolves upon him to be that "someone" and careful thought and consideration should be given by the administrator to make the initial impression a favorable one. Stress should be given to the human element. "How would I like to be welcomed if I were in strange surroundings?" the superintendent may well ask himself.

It must be remembered that the control of the intern staff is dual: for their medical work interns are responsible to the attending staff and for their control, to the administration of the hospital. While these two divisions may appear to be entirely distinct, they become strangely entwined and the administrator must use diplomacy and tact to avoid trespassing.

The selection of interns is usually a function of the medical staff and is assigned to a special committee. Since the applicants have been able to survive twenty years of preparation, it is conceded that all the applicants are good, and since there are from 12 to 20 applicants for each position the choice is excellent, which is as it should be.

The method of selection — written or oral examinations, or both, personal interview, review of individual scholastic records — is an individual problem, each hospital using the method best in its own estimation. After the examination is over, the successful candidates are notified when to report for duty.

Intern services usually begin on July 1 and January 1 but may begin at any time. The control of the new staff begins immediately. A letter is sent to each prospective member, requesting that he report a day before his services begin, at which time he is greeted by the administrator and his assistant.

The hospital has been careful in selecting the intern staff and the men now report for duty with a more or less critical attitude determined to ascertain why this hospital—and what hospital does not?—considers itself superior to others. It is now the hospital that is being examined and the superintendent's

Success in control of the intern staff comes from careful planning on the part of the administrator. This article is one of a series on public hospitals

duty is to see that the institution not only makes a favorable impression but is prepared to maintain it.

Each new incumbent should be given the opportunity of a short interview with the administrator at which time they may become acquainted. It is at this time that the intern is informed what his assignments are and his credentials are again examined. The administrator, in his approach to the new staff member, should learn what his future plans are and whether he desires to do general or specialty practice, should discuss with him his aims and ambitions and from the beginning make him feel comfortable and welcome.

Following the interview, the intern should receive a complete physical examination, including x-ray and laboratory tests, should be assigned to a room, given his uniforms and such equipment as the hospital furnishes, taken on an official tour of the hospital and introduced to his future colleagues. Most important

is his introduction to the house physician or surgeon. Another courtesy that may be extended is introducing the incoming staff to the medical board; the value of this practice is self-evident.

The administrator should then meet the incoming staff as a body and at this time the new interns should be told what is expected of them and what the hospital has to offer in return. At this meeting the administrator not too obviously should create the impression that his office is always open and that they are welcome at any time to discuss their professional or personal problems with him.

The administrator must make it perfectly clear that digression from the hospital rules will not be tolerated and must assure the men of swift retribution if serious digression occurs. He should impress upon them that as long as they adhere to the hospital requirements, he will not interfere with them and that they may rest assured of fair treatment, not as students, but as doctors of medicine, to the ideals of which they are expected to aspire and whose code of ethics they are expected to maintain.

The control of the resident staff is by far simpler. This portion of the house staff is composed of serious minded young men who have had anywhere from one to three or more years' experience in hospitals and who are well adjusted to hospital routine. They are usually the chiefs of the divisions on which they serve and, because of the fact that they are required by the attending staff to control the medical work of their juniors, they are cognizant of their responsibilities and of the problems that may arise. These facts alone make them more willing to cooperate.

In dealing with residents, the important factor to bear in mind is that their position as "chief intern"

should be recognized and problems in connection with their service taken up with them rather than with a junior member of the intern

Following their introduction to the hospital, interns and residents are permitted to go their own way, under indirect supervision. No hospital administrator can hope to supervise any group constantly, so it is his duty to see that the influences under which they come are of the best. To be sure that each group meets with the standards of the preceding group, he must eliminate undesirables and be certain that the ideals of all combined are of the highest.

Serious disobediences, of which there are few, should be dealt with swiftly. However, there should always be leniency, the administrator bearing in mind the constant strain under which the staff works and the long and tedious hours of duty.

When it is necessary to suspend or dismiss a member of the staff, if the administrator has a reputation for fairness, the majority of the house staff will concur with his decision.

House Tradition Carries Weight

There is nothing that plays a bigger part in the control of a staff than the tradition of the hospital. This carries more weight than any words, whether written or spoken. Therefore, the duty of the administrator does not terminate when he has spoken to the staff after they begin their service. He must see that they observe their half of the contract, and he in turn must see that the hospital offers them as much, if not more, than he has promised. Day in and day out, regardless of his many other pressing duties, he must be constantly on the alert for their benefit and must conduct himself in such a manner that he is able to win their friendship and confidence and still maintain the dignity his position demands.

It is difficult to determine where this line should be drawn. This depends on the personality of the administrator and the individual member of the staff. It is necessary for the superintendent to treat each one as an individual and govern his

conduct accordingly. Some persons will never overstep their bounds; others, with the slightest sign of interest, will misinterpret it and become obnoxious. The administrator must not patronize his staff or permit his staff to patronize him. In this way, tradition is developed and handed down from one to another.

Cooperation between the intern and administrative staff, if properly established and developed, can result in many benefits to both. To prove this point, I offer the following per-

sonal experience.

Several years ago I was placed in charge of a hospital in which the educational opportunities were abundant but in which the staff was antagonistic. Little effort had been made to organize the hospital facilities for better intern training, possibly because of the lack of cooperation on the part of the intern staff.

As an experiment, monthly meetings were inaugurated at which time the interns were invited to discuss their problems with the administrator; he, in turn, tried to remedy the cause for complaint. If this was not possible, he explained the reason why it could not be done. This may appear to be unnecessary and a possible waste of time, but after the first meeting was held one of the interns remarked that it was the "first time that he ever felt that he amounted to anything." That in itself was sufficient to continue these conferences, which in time proved to be one of the most efficient methods of intern control.

Pre-existing barriers were broken down and gradually cooperation came about. We also arranged to have an intern representative (this was before the establishment of the Intern Council in Greater New York) elected by the staff to act as liaison officer between the administrative officers and the staff.

While it is not the usual procedure for a hospital administrator to explain his decisions to the interns, it was found to be the foundation for a closer relationship between the intern staff and the "front office."

These meetings also served another purpose in that they gave the hospital superintendent and his assistant an opportunity to bring their problems, complaints and commendations be-

fore the staff as a whole and to observe its reaction. It was interesting to note that while no seal of silence was placed on the business of these meetings, such business as was transacted was not discussed outside the body after the meetings were adjourned. No stenographer was present and no minutes were kept, thereby making the interns feel freer to discuss whatever business happened to be on their minds. What is even more interesting is that the decisions agreed upon were strictly adhered to.

By this means, the morale of the staff was improved and a real interest in the hospital and what it had to offer was established for the first time. With the increasing interest in the work and the improved status of the intern, the desire to utilize the hospital facilities through better organization gradually developed. It was the basis for formulating an ex-

th

ti

cellent training course.

The majority of persons, including interns, hesitate to perform an act that will embarrass them in the presence of someone for whom they have respect and regard. If the house staff views the administrator in this light, they will be more likely to observe his orders.

Not a "One Man Job"

Control of the house staff is not by any means a "one man job." The close cooperation of the medical board, particularly that of the president and the chairman of the intern committee, is essential if the plans of the administrator and the staff are to be carried out. Without this support, the administrator is handicapped. Unless he has their approval and unless they concur with his opinions and are sympathetic to his plans, he cannot even hope for success. With their support, the possibilities are unlimited.

In the final analysis, the basis for staff control, like practically every other activity, is cooperation between the various departments, all of which are working toward the same goals, namely, to give the intern the best possible training under the best possible conditions, to maintain discipline and to afford the best treatment for the patients entrusted to the care of the hospital.

Medical Social Work

A NEW professional specialty was launched thirty years ago to meet the recognized necessity of physicians that their patients' social and economic conditions be studied and planned for as well as their physical and psychic states, so that the diagnosis and treatment of the sick might become more accurate and effective.*

obestof ess

sed

igs

er

ere

ns

ds.

is

ere

he

er-

ad

rst

est

115

ze er

It

X-

ng

lct

es-

ve

ıff

ve

ot

ie

al

i-

n

18

al

Medical social workers constitute that new professional specialty, to be sharply distinguished from social theorists and sociologists. This specialty of medical social work has not yet become established as an individual or private occupation.

It is, however, indispensable for the development, survival and effective use of the institutions and agencies concerned with the organized care of the sick.

Among the eight functions performed by institutions and agencies concerned with organized care of the sick, cited in the Hospital Survey for New York, special consideration was given to medical social service. Among the more important reasons were:

1. Lack of uniformity in the use of social diagnosis and treatment by hospitals and dispensaries.

2. Omission of a department of social work in the administrative and financial organization of many institutions where it was provided.

3. Disagreement as to functions, qualifications, quantity and quality of work to be expected of medical social workers.

4. Confusion in the practices and in the policies of the committees and auxiliaries promoting and supporting departments of medical social service between benevolence and social work, between material relief and diagnosis and therapy in the social field to supplement diagnosis and therapy in the somatic field, as medically understood.

5. Prevalent criticism by welfare, relief and visiting nurse agencies of institutions without a social service department and also of the quality of service provided by those with

such departments.

The Hospital Survey for New York offers for the first time a comprehensive policy in regard to medical social service applicable to all institutions for the sick, approximate bases for units of work, for record keeping, for accounting and for the

A comprehensive policy in regard to medical social service in all institutions has been developed for the first time through the efforts of the Hospital Survey for New York

organization relations of the social service department to the others of a general hospital administration.

That medical social work is intricately involved with other aspects of organized medical care may be seen from the fact that in six other chapters besides the one devoted entirely to medical social work, this essential component is dealt with in appropriate detail.

A social service project in a hospital can be best developed under the following conditions:

1. It should become an integral part of the hospital organization under the supervision of the trustees.

2. A professionally qualified director should be selected to head the hospital's department of medical social service.

3. Relief should be carried on by the organized relief agencies of the community, leaving the hospital social worker as a professional associate of the hospital doctor, primarily conHAVEN EMERSON, M.D.

cerned with the social component of disease as it is related to medical diagnosis and treatment of patients.

4. The director of social service should be authorized to deal directly with the medical staff in matters relating to social factors in diagnosis and treatment without intermediation or diversion through other persons or departments of the hospital or dispensary.

5. Privacy of consultation between the medical social worker and patient is indispensable for the proper conduct of her professional work.

6. It should be made clear to the trustees of medical institutions of all kinds and to the public that medical social service includes within its professional concern and benefits all types of illness and all stages of medical care for in-patients and outpatients and those cared for within homes, whether acute, convalescent or chronic.

7. The director of social service and her staff should be supported in her efforts to keep high qualifications for employment, salaries at a just level and high standards of professional work.

Staff supervision and re-education are as indispensable to good medical social service as to nursing or medical work for hospital patients, and the director of the social service department must be supported in her efforts to provide both supervision and continuous re-education within her staff.

When each hospital, municipal and voluntary, adds a social service department as an integral part of the hospital organization, provided for like other departments within the hospital's budget, and with a director responsible solely to the hospital administrator, the committees and auxiliaries will have achieved their major objective, and can then go on to refinements, improvements and expansion of the service as the needs develop.

^{*}Presented at a meeting of members of hospital committees and staffs of medical work in New York, Nov. 4, 1937, under the auspices of the United Hospital Fund.

Transfusion of

HARRY HALL, M.D.

Drawing the inserted into the vein and the blood is withdrawn by suction on tube.

blood. The blood pressure cuff is inflated to about 80 mm. of mercury and a "head" of blood formed in the forearm. The needle is then

problem. A relative such as a brother, a father or a son is contacted and tested. A man is preferred as he usually has better veins and a higher hemoglobin. But women prove to be satisfactory donors and we do not hesitate to use them.

Any individual from 15 to 65 years of age who is in good health, who has a negative Kline or Wassermann reaction, who gives no serious allergic history and who has had no recent serious infection may be used. Occasionally a postoperative patient who has had an appendectomy or hernioplasty may be used as a donor if his general condition is satisfactory. Patients on the medical service with hypertension often make suitable donors.

After the possible donors are selected, their blood is grouped. In this hospital we follow the Moss classification, which places the universal donor in group 4. The grouping may be done in two ways. First, the direct or rapid method consists of mixing a drop of fresh blood from the donor with a drop of group 2 serum on one end of a glass slide and a second drop of blood with a

drop of group 3 serum on the other end of the slide. Macro-agglutination, if present, may be seen in from three to five minutes. This may be confirmed by microscopic examination in doubtful cases.

The indirect or delayed method consists of putting a drop of the donor's blood into from 2 to 3 cc. of citrated saline solution. A drop of this cell suspension is then mixed with a drop of group 2 serum and a second drop is mixed with a drop of group 3 serum. One-half hour later microscopic examination will show the results from which can be determined the donor's group. If the donor is in the same group as the recipient or is in group 4, his blood is then matched with the blood of the patient.

Matching and cross-matching of blood are two distinct procedures. Matching consists of mixing the donor's cells with the recipient's serum. Cross-matching consists of the foregoing procedure followed by mixing a drop of the recipient's cells with the donor's serum. Matching is the routine procedure with us.

At the same time that the matching is being done a Kline test is run on blood from the donor. If the transfusion is an elective procedure, a Wassermann test can be done on the donor several days in advance and the Kline test may then be omitted. If no agglutination is present and if the Kline test is negative, the donor is called suitable. If slight or even moderate rouleaux formation has occurred, this is not considered unsatisfactory although the patient is carefully observed when he receives the blood. Occasionally an emergency arises when group 4 blood is given without preliminary matching. Close observation of the patient must be maintained when this procedure is carried out.

The next procedure is to draw the blood. The donor lies on an examining table in the treatment room. The

HE transfer of blood from a healthy individual to an ill patient has become such a valuable and necessary procedure in the treatment of disease that a description of a simplified technic may prove to be of value to many hospitals and physicians who fail to use transfusions on many occasions because of inconvenience and technical difficulties.

At the University of Minnesota Hospital, Minneapolis, indirect transfusions of citrated blood are given except on rare occasions when whole uncitrated blood is used. For the last six years transfusions have been performed by following a standard easily mastered technic with a simple apparatus. In this article a detailed description will be given explaining each step from the choosing of a donor to the sterilization of the equipment.

All patients in the University Hospital are grouped on admission except those cases admitted to the pediatrics service. In that department grouping is done only when it is necessary.

After deciding upon a transfusion, the selection of donors is the next

Stored Blood

arm is bared to the shoulder and a blood pressure cuff is wrapped around the upper arm to serve as a tourniquet. Then the arm is loosely strapped to an arm board with the palm upward. The antecubital space is prepared with iodine and alcohol or merthiolate. Following this, the transfusion set is assembled by the doctor who wears sterile gloves.

D.

her

na-

om

be

na-

bon

the

cc.

of

red

d a

of

ter

ow

de-

the

he

od

of

of

es.

the

ıt's

of

by

lls

ng

h-

un

he re, on ce be esve, ht adhe he an $^{\rm od}$ hnt 0-

ne nne

IL

Our set consists of the following parts, each wrapped separately and all packed together in a porcelain tray, 10 inches wide and 16 inches long, and autoclaved:

1. A wide mouth liter jar.

2. (a) A three-hole rubber stopper, size 9. Into two of the holes have been inserted two 14 cm. lengths of a 5 mm. lumen diameter glass tubing (b) which protrude through the bottom of the cork for 6 cm. From the top of the cork these tubes are bent at right angles and to the ends are attached two 24 inch lengths of amber gum rubber tubing (c) with a lumen 4 mm. in diameter. One of the rubber tubings has a glass adapter (d) at the distal end and the other a Murphy drip bulb (e) so arranged that any liquid entering the open end of the tip will collect in the bowl of the Murphy drip tip

Giving a transfusion. Blood from the flask is permitted to run in at the rate of 100 cc. in six to eight minutes. Below is shown apparatus ready for drawing the donor's blood and for giving the transfusion.



and not run down the rubber tubing. Into the third hole of the rubber stopper a one way stopcock (f) is inserted to which has been soldered a 6 cm. length of steel tubing with a lumen 5 mm. in diameter. This tube extends through the rubber stopper the same distance as the two glass tubings.

3. A 2 cc. syringe.

4. A 20 cc. syringe.

5. Four needles: one hypodermic, one 17 gauge, two 15 gauge.

6. A glass funnel with a wide mouth.

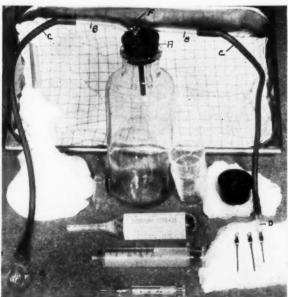
7. A solid rubber stopper, size 10.

8. Two 1 ounce medicine glasses.

9. A Wassermann tube.

10. Cotton applicators and gauze fluffs.

After the foregoing equipment is unwrapped, the three hole stopper





with attachments is inserted into the wide mouth liter jar. Either a 15 or 17 gauge needle, depending on the size of the donor's vein, is attached to the adapter. A 15 gauge needle is preferred if the vein is large enough. This set is air tight and the only openings are one at the needle end and the other at the Murphy drip tip bulb.

The set is now ready for use. A 2½ per cent solution of sterile sodium citrate is siphoned through the needle, adapter and rubber tubing by having an assistant create a partial vacuum in the liter jar by sucking on the Murphy drip bulb.*

A 50 cc. ampule of sodium citrate solution is poured out into a medicine glass and from 20 to 30 cc. of citrate solution are siphoned through, 10 cc. being allowed for every hundred cubic centimeters of blood to be drawn. In this way the citrate solution is transported aseptically into the jar and at the same time the needle, adapter, tubing and jar are bathed in citrate solution, thereby lessening the possibility of clotting. A wheal of novocain is injected into the skin over the vein.

Drawing the Blood

When all is ready, the blood pressure cuff is inflated to approximately 80 mm. of mercury and a "head" of blood is developed in the forearm. Any pressure above venous pressure and below systolic pressure is satisfactory. The needle is inserted into the vein with the point directed proximally. At the same instant the needle enters the vein, suction is applied to the Murphy drip bulb. Blood will flow rapidly into the liter jar taking from ten to twelve minutes for 500 cc.

Care must be taken to see that too much suction is not used or else the vein collapses and the point of the needle is pressed against the vein wall. As the blood is siphoned into the bottle, the assistant may close the Murphy drip bulb with a finger. He soon learns that many times only a minimal amount of suction is needed to siphon the blood. Holding the jar below the level of the vein adds considerably to the force of the siphon-

age. Gentle rotation of the jar is maintained in order to produce a thorough mixing of blood and citrate.

After the amount of blood drawn takes up the initial amount of citrate in the jar, an additional amount of citrate solution is drawn into the 20 cc. syringe. The tip of the syringe is then inserted into the hole of the one way stopcock and this is opened temporarily while the citrate is injected into the jar, 10 cc. being added for every extra hundred cubic centimeters of blood to be drawn.

Preparations for Storage

After the desired amount of blood is obtained, the pressure cuff is deflated, the needle withdrawn and the suction discontinued. The remaining few cubic centimeters of blood left in the tubing are then allowed to drip into the Wassermann tube which contains 1 cc. of sodium citrate solution. A few cubic centimeters of citrate solution are siphoned through the needle and tubing to remove any remaining blood. The three hole stopper is removed and the solid rubber stopper replaces it.

In this way the liter jar is sealed tightly. Several sterile fluffs are laid over the top of the stopper and adhesive is used to tape the fluffs and stopper tightly to the jar. The Wassermann tube containing citrated blood is bound to the side of the liter

If any further tests for compatibility need to be done, the blood is obtained from the tube and in this way the large bottle need not be opened. The liter jar is labeled with the donor's name and group, the intern's name and the result of the matching. Sterile technic should be used throughout the entire procedure.

A blood bank, at which the intern deposits or draws blood, is not used at this hospital. Each intern is responsible for obtaining donors for his patients. If one intern is short of blood or has none that is compatible with his patient, he borrows from one of the other interns. Later he repays his lender or cancels his debt, depending upon the arrangements he can make. This system has worked out satisfactorily.

When a transfusion is given, the blood is brought to body heat in a pan of warm water. In the meantime an intravenous infusion apparatus is set up. This consists of a 700 cc. Kelly flask of heat resistant glass with a 1 inch diameter mouth and a funnel shaped bottom tapering off to a tip with a lumen 6 mm. in diameter. To the lower end is attached a 4 foot length of gum rubber tubing with a 6 mm. lumen. To the other end of the tubing is connected a glass adapter to which can be attached any standard sized needle; at this hospital a No. 19 gauge needle is preferred.

later

her

serv

enty

and

Thi

jaul

velo

dela

alde

10

obs

trai

blo

old

abo

blo

we

to

em

col

sio

SVI

SIO

in

tio

ce

se

fo

he

of

B

th

fr

ce

ti

(

The flask is suspended from a standard 2 to 3 feet higher than the patient. Two hundred cubic centimeters of warm saline solution are added to the flask and the air is excluded from the tubing. Next, the arm of the patient is bared and strapped to an arm board with the

palm upward.

Giving the Transfusion

After preparing the arm with alcohol, a tourniquet is tightened about it above the elbow and the needle is inserted into the distended antecubital vein. Then the tourniquet is released and the saline solution is allowed to run into the vein.

Following this, a sterile funnel with fluffs in the bowl part is inserted into the mouth of the Kelly flask. The blood is immediately poured through the funnel into the flask. After all of the blood has run in, a small amount of saline solution is used to wash through any remaining cells. Blood may be allowed to run in at the rate of 100 cc. every one to two minutes in emergency cases, while the usual rate of flow is 100 cc. in six to eight minutes.

Symptoms of any immediate reaction usually occur after 50 cc. of blood have entered the vein, so the patient is closely observed until at least 100 cc. have run in. The most common signs and symptoms of an immediate reaction are sudden severe chest pain, dyspnea, severe headache or a peculiar apprehensive feeling and appearance. A shaking chill may be seen occasionally from ten to fifteen minutes after the blood has entered the circulation. Any or all of the foregoing phenomena may occur.

Late manifestations of a reaction are jaundice and hemoglobinuria from twelve to twenty-four hours

^{*}A rubber suction bulb may be used in place of the Murphy drip bulb.

later. During the month of December 1937, 40 patients on the surgical service were given transfusions. Seventy transfusions were performed and 40 liters of blood were given. Three of these patients became jaundiced and one of the three developed hemoglobinuria. A late or delayed minor reaction may be heralded by a temperature rise of from 1° to 3° F.

ap-

ant

ith

ng

in

at-

er

To

n-

an

ed 19

he

ti-

re

X-

he

nd

he

ut

is

)1-

is

ly

ly

ie

e

e

Only a few such occurrences were observed in the foregoing number of transfusions. Transfusion of stored blood that is more than seven days old has been observed to give rise to about 5 per cent more reactions than blood less than a week old. As a rule, we do not use blood more than five to six days old unless some great emergency arises.

Only a brief résumé will be given concerning the treatment of transfusion reactions. At the first sign or symptom of a reaction the transfusion should be discontinued. A syringe containing 1 cc. of adrenalin should always be ready for instant injection and should be given in 0.5 cc. doses subcutaneously if any reaction does occur.

If the transfusion is an elective procedure, the patient should be observed for signs of shock. If this occurs, the usual shock treatment procedure such as elevation of the foot of the bed, the application of heat and the hypodermic injection of morphine should be carried out. But if the patient is being given a transfusion because he is in shock, the patient should be given blood from another donor who is of the same group as the patient. This procedure is also advisable in the treatment of reactions following elective transfusions.

Alkalization of the patient is said to aid in the prevention of the formation of cast in the kidneys. Most of our reactions have occurred in patients who have received multiple transfusions in rapid succession without matching between each transfusion.

Sterility has not proved to be a serious problem. Repeated cultures of the stored blood have been taken. About 50 per cent of the cultures showed a scant growth of Staphylococcus albus. No signs of any infection have ever resulted from the

giving of this blood. Not even a temperature rise was seen. Most probably the Staphylococcus is a contaminant which is encountered at the time the blood is drawn.

The bottled blood is stored in an electric refrigerator in which the temperature varies between 45° to 50° F. Hemolysis occurs anytime after the seventh day. Slight hemolysis is not a contraindication for transfusion but any blood showing moderate hemolysis is discarded. We have used blood 42 days old when it showed only slight hemolysis. A definite rise in hemoglobin was seen in patients receiving this blood. But, as a rule, blood not over seven days old is given, unless some great emergency arises. A hemoglobin rise of one point (Sahli) per hundred cubic centimeters of blood transfused is the usual response.

All the equipment is washed in cold water immediately after its use. If this policy is strictly followed, the apparatus can usually be washed free of any blood before it becomes dried or clotted. Later, all the glassware is washed three times in cold water using a brush if necessary to remove any adherent blood.

Amber gum rubber tubing is used so any remaining specks of blood can be seen through its translucent walls. If it is impossible to wash free all of the blood, the tubing is discarded. If any opaque rubber tubing is used, it is discarded once blood has passed through it. Both the glassware and rubber tubing are rinsed three times with distilled water and dried.

Supplies Saved by Cost Study



Instruction of undergraduate nurses in operating room technic at the City Hospital School of Nursing in Cleveland includes several cost study projects of the equipment and supplies handled by pupil nurses in the surgery. These students are permitted to present the results of their projects. The foregoing chart is the work of Mary Louise Greenman.

Plant Operation JOHN MANNIX AND R. C. BUERKI, M.D. Air-Borne Infections*

HE remarkable reduction in L cross-infections following the application of aseptic technic has led at times to complacency on the part of the hospital staff and complete confidence on the part of the public regarding the transfer of infection within hospitals. Such infections as do occur have been attributed to a breakdown in nursing technic, a point of view which has prevented the frank and open discussion of the residual infections. Only those hospitals with methods beyond suspicion

can afford to recognize the problem of cross-infection or to suggest that it may be other than hand-borne.

So long as, through improvements in aseptic technic, the number of infections was being continually reduced, hospital administrators were justified in assuming contact to be the source. When, as in many hospitals today, no further reduction is being accomplished, some other source of infection should be sought

to account for those remaining. McKhann¹ has recently given a summary of the problem of hospital

WILLIAM FIRTH WELLS

infections. By means of the newer laboratory technics which permit cross-infections to be traced as both clinical cases and subclinical infections, we are coming to realize how much more numerous they are than had been supposed.

Clinical cases of nasopharyngeal infections may constitute, according to advanced work, particularly in England,2 rare outcroppings of epidemic strata of subclinical infection which can be located by the newer technics of bacterial typing. By such procedures the latent image of the mode of spread of nasopharyngeal infection, manifest in such diseases as measles and influenza and deducible from epidemiologic studies of age incidence and immunity tests,3 may be developed.

Coincidently improvements in the technic of air bacteriology have initiated studies upon the bacteriologic behavior of air that reveal a mechanism which not only permits a theory of air-borne infection but which proves beyond reasonable doubt that we are exchanging within our enclosed rooms respiratory flora.

The consequences are as inevitable as the exchange of our intestinal flora through the medium of water or of food. It is significant that the classes



The white arrow indicates the light barrier placed across a corridor of the isolation unit of the Children's Hospital in Boston

¹McKhann, Am. J. Dis. Child 55:679, 1938. ²Okell and Elliott, Lancet 2:836, 1936; Allison and Brown, J. Hyg. 37:1 and 153, 1937; Keevil and Camps, Lancet 2:207, 1937; Cruikshank, Lancet 1:841, 1938.

³Dudley, Medical Research Council, Special Report Series, Nos. 75, 111 and 195; Aycock, Am. J. Hyg. 8:35, 1928, and J. Prev. Med. 4:189, 1930.

^{*}This study is supported by a grant from the Commonwealth Fund to the University of Pennsylvania for investigations on air-borne infection, with laboratories in the department of bacteriology, the Children's Hospital, and the Henry Phipps Institute for the Study, Treatment and Prevention of Tuberculosis.

Below: An example of direct irradiation in operating room of New England Deaconess Hospital, Boston. Right: Testing an experimental cubicle for bacterial tightness at Henry Phipps Institute, Philadelphia.





of infections that remain after such mediums are controlled are typically those that enter and leave through the respiratory tract. Evidence⁴ substantiating these facts is, briefly, as follows:

LLS

ning. en a spital

atory tions and ning crous d. geal ding in

epi-

tion

wer

uch

the

geal

ases

de-

lies

ity

the

ni-

gic

ch-

a

ut

le

in

a.

ole

ra

of

es

m

ne

nd

y,

ıl

1. During coughing and sneezing, minute droplets containing microorganisms from infected surfaces may be ejected into the air.

2. Most of these droplets are sufficiently small to evaporate before they can settle to the ground, leaving suspended in the air minute residues.

3. These nuclei, in which the micro-organisms remain viable for considerable periods, may drift in air currents like particles of cigaret smoke.

4. The air breathed commonly by the various persons congregated in a room or other enclosed space can thereby transfer organisms from one person to another and plant them upon the susceptible tissues of the respiratory tract.

Drifting particles, arising from common occupancy of enclosed spaces, constitute a hygienic hazard which may be reduced through the elimination of the micro-organisms thus suspended in air.

When individual supplies of air can be furnished to each person, the problem of air-borne infection disappears. Blackfan and Yaglou⁵ report a spectacular reduction in acute and chronic infection of premature infants, chiefly respiratory, by the installation of a separately conditioned air supply for their ward. Incubators for premature infants may, by providing an individual supply of pure outside air to each infant, attain this theoretical ideal, for even the nurse is excluded from the child's atmosphere. The DeLee⁶ and Chapple⁷ incubators, by providing an individual supply of pure outside air to each infant, attain this theoretical ideal.

Whether the principle of the individual air supply can be profitably prolonged beyond the premature into the normal life span is a problem in hygiene as well as in engineering.

⁶Blackfan and Yaglou, Am. J. Dis. Child. 46:1175, 1933.

⁶De Lee, Chicago Med. Rec. **22:**22, 1902.
⁷Chapple, Am. J. Obst. and Gyn. **35:**1062, 1938

In general, however, the engineer must provide for common occupancy of enclosed spaces. The magnitude of this hazard depends upon the degree of confinement of the air common to many persons, or rather upon the concentration of the contaminating nuclei, which varies directly with the number of persons occupying a given volume of air (and their specific infectivity, which in hospitals is of particular importance), and inversely with the dilution either with pure air from without or with any other equivalent means of elimination of the micro-organisms, such as precipitation, filtration, washing, physical or chemical disinfection.

As Colvin⁸ has said, "The fundamental factors in prevention or control of droplet infection become evident. Dilution of the droplets by air space or change of air provides the barrier, *i.e.* proper space for each one, especially in sleeping, and proper ventilation."

Sanitary ventilation may, therefore, be defined as the rate at which micro-organisms are vented, or as the proportional air replacement (expressed in turnovers per hour) that would remove the equivalent number of micro-organisms eliminated by any other means.⁹

With the modern technic of sani-

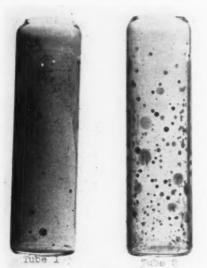
⁸Colvin, Am. J. Hyg. 15:247, 1932.

⁹Wells and Wells, Am. J. Pub. Health 28:343, 1938.

tary air analysis, the equivalent air replacement can be simply determined. A diluted culture of the test organism is thrown into the air by an atomizer which may be designated the infector. Following the instantaneous evaporation of the droplets, the contained bacteria remain suspended in the air like an invisible smoke. The bacterial concentration may be determined by the air centrifuge, which represents a mechanical infectee. The specific technic is contingent upon the dimensions involved.

It becomes possible, therefore, by a suitable technic to measure directly the degree to which an infector at any point in a confined space infects an infectee at any other point under given conditions of ventilation. By comparing these measurements under varying conditions of ventilation





Courtesy of Dr. C. F. McKhann.

we are provided with a quantitative instrument for measuring sanitary ventilation as defined above.⁹

Sanitary interpretation of equivalent ventilation then defines a scale of sanitary ventilation. During the winter months, the season for the spread of respiratory infections, we congregate indoors. With closed windows and no special provisions for ventilation other than natural seepage of air around windows and doors less than 10 turnovers per hour have been found over a large number of determinations. The ventilating conditions represented by less than 10 turnovers per hour we consider bad.

Ventilating systems can be designed under practical conditions to double the rate of pure air replace-



showing nasopharyngeal streptococcus colonies (circled) in (1) irradiated and (2) control air of railway cars in service. Left: Samples of air (1) premature ward, (2) and (3) children's wards. Counts: 18-0; 813-5; 1278-1 total and alpha-streptococcus colonies.

Tubes (above)

ment. Under exceptional conditions they may increase the turnovers to 25 per hour. Still no good epidemiologic evidence proves this to be a general solution of the problem of air-borne infection. From 10 to 25 turnovers per hour, then, represent conditions of sanitary ventilation which we class as poor.

Opening windows in mild weather under favorable climatic conditions increases the turnovers, though seldom have we found them to exceed 100 per hour in our habitations. Under such conditions, however, respiratory infection shows a marked decline, so we believe that from 25 to 100 turnovers per hour ordinarily indicate fair conditions of sanitary ventilation.

The introduction of ultraviolet

radiation as a new factor in ventilation has made practicable turnover values above 100, which we hold to be good, and even more than 500, which we hold to be excellent sanitary ventilation.

ma

tec

tai

ma

roo

ult

un

ho

SIL

T

OI

Micro-organisms ejected in droplets and suspended as nuclei are destroyed by this means at a rate far greater than can be accomplished by any method of mechanical ventilation and at a greater rate than can the same organisms be destroyed by ultraviolet radiation when suspended in dust particles.

It may be of interest to consider briefly the practical conditions and limitations under which we have obtained adequate turnover values, as determined by the methods for measuring sanitary ventilation.

The irradiation of recirculated air constitutes a simple case of bacterial ventilation by means of ultraviolet light. If the efficiency of such ventilation is determined by samples taken within the recirculation system before and after irradiation, the fraction of the bacteria removed represents the fraction of the recirculated air which presumably replaces with pure air the contaminated air of the room.

Equivalent sanitary ventilation is thus limited by the rate of recirculation. If only 10 per cent of the air is recirculated per minute, the highest equivalent ventilation by any system of purification or by supplying entirely fresh outside air would be six turnovers per hour.

Compared with the sanitary ventilation obtainable by treatment of the whole volume of air of occupied spaces, this fractional method of replacement of room air with pure or purified air by mechanical means hitherto available to the ventilating engineer is completely out of range.

In special cases, such as railroad cars, the rate of recirculation may be as high as 20 turnovers per hour and, therefore, the irradiation of the recirculated air provides a feasible method of sanitary ventilation.

In the previous case the change in the room air is given by a percentage reduction of a percentage recirculation. Direct irradiation of the whole room is far more effective in instances in which the eyes of the occupants can be protected. An operating room furnishes a special instance of such irradiation, since the discipline maintained permits responsible protective measures. Here reflectors containing the burners, installed in the angles where ceiling and walls meet, provide general irradiation of the major portion of air in the operating room and throw a broad beam of ultraviolet light on to the operating table.

tila-

over

d to

500.

ani-

lets

de-

far

by

tila-

can

by

ded

der

ind

ob-

ies.

for

air

ial

let

ıti-

en be-

ac-

re-

ed

ith

he

la-

18

est

m

ix

ti-

1e

ed

e-

or

g

d

e

n

e

This type of installation has been under test by Dr. Richard H. Overholt of the department of thoracic surgery, New England Deaconness Hospital, Boston, for about one year. The ventilating power of lights so installed appears fantastic when converted into turnovers per hour.

Direct irradiation, however, applies only to special cases. The general problem of the sanitary air control of hospital wards, schools and public institutions must be solved by partial irradiation, where the space without the eye zone is directly irradiated. The irradiation of the upper air of a room may be regarded as equivalent to removing the ceiling, or ventilating upward instead of by windows, if the air circulation could then be comparable to that in a room. The disinfection of the air in the unirradiated zone depends upon air movement through the irradiated space, as well as upon the spatial distribution of the radiation.

Efficiency Factors

Careful design, operation and regulation, necessary in all sanitary light installations, are of particular importance with partial irradiation because efficiency rests primarily upon the relationships established between the irradiated and unirradiated portions of the room. The integrated product of intensity and time of exposure for all of the living organisms within the space, which determines the number killed, mathematically predictable in ideal geometric configurations, must be bacteriologically determined in the practical solution of partial irradiation.

Tests have shown the practicability of obtaining equivalent ventilation of 100 turnovers per hour in a room of 5000 cubic feet capacity when irradiated by a 12 inch quartz Geissler tube reflected upward above the eye level in the center of the room. They also show the necessity for basic experimental work to provide scientific data upon which sound design principles may be established and responsible.

sible regulatory measures developed.

Until opportunities to test buildings especially designed for irradiation become available, experience gained with empirical installations must serve to provide working principles and to guide in tentative regulation. Such experimental installations are now being tested at the Children's Hospital, Philadelphia, and the Marlboro State Hospital at Marlboro, N. J.

The discussion of indirect irradiation disregards the factor of reflection. With ordinary interior surfaces this factor is negligible. By the proper choice of surfaces, however, diffuse reflection, since it represents the efficiency of direct irradiation, may be an important positive factor in the elimination of organisms throughout the room.

Even though the radiation is of low intensity at any occupied point in the room, its wide distribution throughout the whole space may give it a relatively high importance compared to the intense radiation of a portion of the room. The advantages of both methods are obtained without the disadvantages of either. Of course, the intensity must not be high enough to affect the occupants of the room.

Ultraviolet light screens or barriers constitute another special application. This new, important principle was first applied by Dr. Charles Mc-Khann to a corridor in the isolation unit of the Children's Hospital, Boston, and this has been under test for more than a year. Here a light barrier thrown across a corridor separates two contagious diseases. The efficiency of bactericidal power may be determined directly under the actual ventilating conditions in the corridor, the infector being placed on one side of the barrier and the infectee on the other, samples being taken with the lights on and off. The infector and infectee are then reversed and the test duplicated.

Tests thus made have shown that light screens can be made practically impervious to bacteria suspended in droplet nuclei and carried by ordinary ventilating currents.

The air of cubicles separated from the surrounding air of a ward by ultraviolet light screens can be tested either by placing the infector within and the infectee without (representing the protection offered the surrounding ward from a person ill within the cubicle), or by placing the infector without the cubicle and the infectee within (representing the protection offered a person within the cubicle from the surrounding ward). In each instance the bacterial tightness of the light-enclosed space is determined bacteriologically. Experimental cubicles have been set up and are under test in the Henry Phipps Institute, Philadelphia, in collaboration with Carl A. Erikson of Schmidt, Garden and Erikson, Chicago.

The dramatic nature of this new element in sanitary disinfection should not blind the practical administrator either to its limitations or to the great benefits that can be obtained without its application if only the principles of pure air are applied. The pollution load upon air depends as much upon the rate of addition of micro-organisms to the air as upon their rate of removal.

Excessive Bacterial Load

One of the most important results of the studies has been the discovery that hospital air carries a bacterial load enormously in excess of the air outside the hospital. These organisms, of hospital origin, must carry the burden of proof that they are innocuous, for their associations provide most damning circumstantial evidence.

The reduction in infections of premature infants may be largely due to the exclusion, through provision of a separate air supply, of the ward air to which the infants were previously exposed. An operating room may receive protection by the exclusion of the ward air from the hospital as well as by combating the air-borne organisms with ultraviolet light.

In general, the problem of providing pure air, as pure water or pure milk, commences with provision of a pure supply, maintenance of the purity, as well as the safeguard of purification. Purification of air, as of water and milk, is but an added factor of safety against the breakdown of other agencies, mechanical and human, which play a part in the prevention and control of air-borne infection. More important than any device are proper design and the intelligent and conscientious operation upon which depends the safety of those admitted to a hospital.

Maids in Uniform

OOD appearance of maids and G neat equipment are essential in the smaller as well as in the larger institution. It is far easier for the maids to look trim and neat at all times if a standard uniform is worn.

Most maids take pride in their uniforms, particularly if the style and make of the garment are to their liking. They feel instinctively that a becoming uniform gives them a professional status and this attitude is sure to be reflected in their work. In any event, uniformed maids look far more efficient than does a similar group garbed in hit-and-miss house dresses or old street dresses.

When buying uniforms it is important to choose a style that is simple, yet smart, one that is comfortable and so designed that it is easy to work in. It should have no tucks, folds or drapes to make laundering difficult and for the same reason buttons should be of rubber or at least as flat as possible. The material should be a sturdy fabric, preshrunk and colorfast. To ensure maximum wear the material chosen should be of proved wearing quality.

Items that should be checked as a further guarantee of long wear are reenforcements such as those at the plackets, armholes and pockets. Seams should be lockstitched. In case white collars and cuffs are worn, it is desirable to have one or more extra sets; nothing freshens up a uniform so quickly as an immaculate collar and cuffs.

The housekeeper has a wide choice as to color of uniforms. Occasionally it is desirable to choose one that harmonizes with the general color scheme of the hospital. Many prefer a soft grayed blue. As long as the color is not one that soils easily, gay shades are best. Avoid drab uniforms; they make drab personnel.

Shoes are as important as the dress. A properly fitted low-heeled shoe not only looks businesslike but it actually contributes to efficiency and comfort since the maid spends

ALTA LaBELLE

most of her time on her feet. The habit of wearing jewelry with the uniform must be discouraged.

Adequate equipment for maids usually is provided but its care often is neglected. At the end of the day maids get in a hurry to leave and frequently it is a temptation to put away the work things without cleaning them or returning them to their proper places.

If each maid is provided with a closet or locker to which she is given the key in the morning when she checks in and returns when she checks out at night, this problem is reduced to a minimum. Unfortunately, this is not always possible. If she shares a closet with many other maids and each has access to it, keeping working supplies in good order is hardly possible.

There always is someone who needs to borrow some article and



This uniform is easy to work in.

who neglects to return it. Any housekeeper who has sent a new maid to an equipment closet when starting out the day knows how annoving it is to find things not clean or missing. Such a situation not only delays the work but gives the new worker a bad first impression.

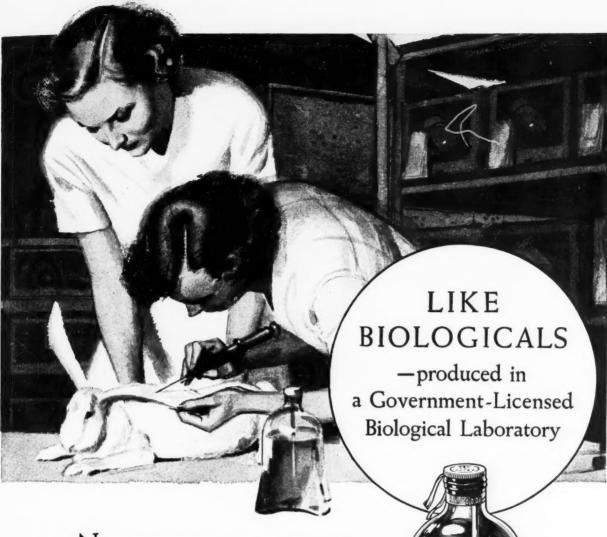
At the end of the day each maid needs a little time to clean her equipment. Once each week she needs to make a thorough job of it. This time can best be spared on those days each week when the routine is somewhat lighter. A maid should be encouraged to manage her time so that she will always have her working tools in good condition. Usually just the suggestion that she allot a certain time to this task is sufficient, for she will welcome the change in routine.

Pails, scrub cloths and scrubbing brushes should be cleaned at the end of each day. The dust mop is more of a problem. It must be washable, of course, and when it is to be used a great deal, two mops should be provided, so that a clean one will be at hand while the other one is drving.

Carpet sweepers and vacuum cleaners need to be emptied and cleaned after work every day. Both should be checked once each week by the houseman, who will take care of oiling and minor repairs so as to keep them nice looking and as noiseless as possible.

Hair brooms need to have the dust removed from them daily or they will mat and become useless long before they are worn out. As often as seems necessary they may be washed in good suds. The handle should be reversible, so that the brush will wear evenly.

Kneepads, notoriously hard to keep clean, may be slip covered in dark blue or brown denim. Since the cover will probably need changing each day, have the covers made in the sewing room and cut so that they fit snugly and yet may be removed easily. Rubber and composition pads, in our experience, neither wear nor wash as well as does the cotton or hair pad.



No law exists which permits government licensing of dextrose solutions. But such solutions, produced in a laboratory equipped for the production and meticulous testing of biologicals—a laboratory staffed by technicians of the calibre demanded in a government-licensed biological laboratory—are safe solutions.

The careful clinician appreciates that *no* product—licensed or not—is safe for intravenous injection unless it has been *proven* safe.

Dextrose Solutions in Saftiflasks are tested as exactingly as biologicals. Tested chemically, biologically, physiologically—by technicians who have nothing to do with the products' manufacture.

For safety—specify dextrose and other solutions in Saftiflasks. Easy to use. Available in half-liter, one and two liter sizes. Cutter Laboratories (U. S. Gov't License No. 8) Berkeley, Calif. 111 N. Canal St., Chicago.

DEXTROSE SOLUTIONS IN

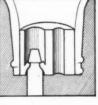
Saftiflasks





SIMPLE!

Only one part required to A connecting tube which is supplied with each case of Saftiflasks . . . Patented soft rubber stopper



fits any connection tube . . . Connection tube becomes integral part of your injection out-fit. No loose parts to wash, sterilize, and reassemble. No involved technique, with resultant mutiple sterility hazards.

Any new then anlean only new

aid uips to his ays

neen-

so rklly

nt,

in

ng nd ore le, ed be ill

is

m

th

k

to

e

What About Vacation Schedules?

SUMMER is generally the time when the hospital housekeeper expects, and is expected, to do some renovating. There are always rooms to be painted, furniture to be repaired, hangings to be replaced and other details that can best be attended to when the patient load is light.

Yet summer is also vacation time. What is to be done about it? Must extra help be brought in or can the work be carried on adequately by a careful arrangement of vacation schedules?

These questions can best be answered by finding out first hand what the specific problems are and what are their solutions. Suppose we stop first at the Albany Hospital, Albany, N. Y., and talk for a few minutes with Althea C. Berry, superintendent of housekeeping. A few years ago in her hospital the problem of vacations and summer renovations was a comparatively simple one. The rooms and wards were then much lighter during months of June, July and August so that supply maids and porters were unnecessary.

"We could easily cover the work of the ones away by those whose sections were running low," she states. "Also, rooms were always available for washing of walls and repairing. When the fall illness again arrived, we were shipshape.

"All this has changed, however, in the last few years. We now seem to have no time in the year when the load lessens precipitantly. This means extra maids and porters have to be put on to cover vacations.

Generous Vacation Policy

"The housekeeping vacation period runs from A 1 to October 30, inclusively. Our policy of giving vacations is, I think, a generous one. The people working one year beginning with the year starting January 1 have one week with pay. After two years' continuous service, two weeks with pay is allowed. A percentage of days is given those whose service is under one year.

"In scheduling vacations I plan them in sequence so that no intervening time is left open for the supSeveral housekeepers tell how they plan the work so that employes may take their vacations without disrupting hospital routine

ply. If a supply can be assured of steady work rather than a week of work and a week layoff, a fair amount of certainty of the same person remaining all through the season is assured.

"If an employe is resigning, his vacation automatically cancels. Vacations are given to prepare the worker for the work in the future and not as a reward for past service. Giving vacations is purely a health measure provided to fit employes for the coming year's work. Fifty per cent of vacation pay is allowed in advance, the balance being paid on the employe's return to work. In the event the employe does not return at the expiration of the vacation period, he forfeits the balance due.

"Renovations have to be done when and where vacancies occur. Washing walls before painting them ensures a much better result. If possible, a freshly painted room should be aired at least twelve hours before admitting a patient.

"We find there are times when an occasional washing job can be carried on even if there are patients in a ward or a room. This depends, of course, on the condition of the patients occupying the space. Many times a patient welcomes a break in the monotony which wall washing furnishes.

"For repair and refinishing the furniture is taken out of the room and to our maintenance shop. This can be done piece by piece at any time regardless of crowded conditions in the hospital."

While in Albany we shall also drop in upon Jessie L. Wilson at Memorial Hospital and find out what her experience has been. What she says about it is encouraging:

"The vacation problem has never been a great hardship to me. I have several girls who come in to relieve when maids are ill or off duty. As my force is small, I can always plan to have the relief maids in for vacation time. My wall washer takes over the porters' work when they are away.

"Maids and porters are given one week with pay and can have an extra week without pay after being employed for one year. They generally take two weeks.

"As our hospital is located near the railroad and in the wholesale district, spring cleaning goes on all year round. Rooms are washed and painted whenever they can be spared for a day or so.

"The wards are the real problem as they are never empty. When we have no seriously ill patients I put two or three men in to wash the walls. The painting has to wait until we have empty rooms to move patients out of the ward for a day or so.

"When our hospital was built, housekeeping was not as important as it is today. Maids' closets, hoppers and many present day essentials were not provided; therefore, the housekeeper has to invent ways to keep her department in order and to give her maids or porters the best help she can.

Day Mops and Night Mops

ree

in

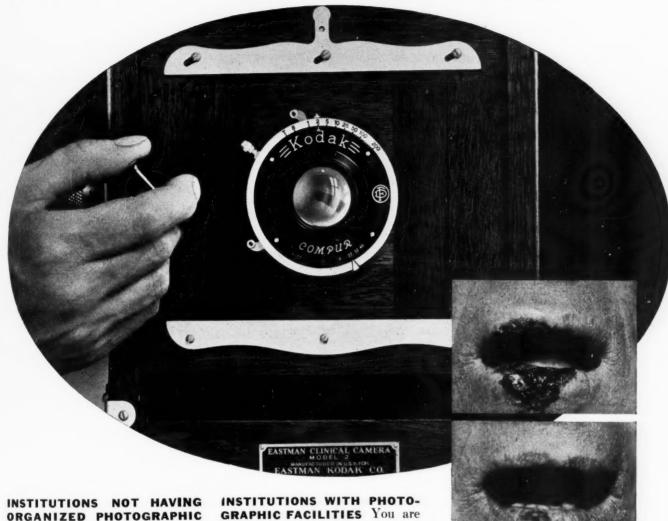
pi

"Wet floor mops are in use twentyfour hours a day, so we have day mops and night mops. To keep them odorless, the day mops are on the roof all night to air and night mops air all day. Isolated rooms have their own mops, wringers and pails. They are sterilized, aired and ready for the next time they are needed.

"We have maids' baskets. In them they carry whisk brooms, furniture polish, papers for the bottom of the waste baskets and dust cloths. This saves running back and forth and everything is kept together.

"As I have said before, we have no maids' closets, so in order not to have

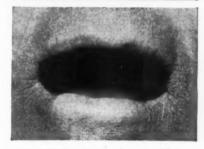
PHOTOGRAPHSMAKE HOSPITAL RECORDS COMPLETE



ORGANIZED PHOTOGRAPHIC FACILITIES Consider how photography can contribute to every phase of hospital activity: Case histories ... staff conferences ... teaching...addresses to profession and laity ... scientific exhibits ... records of personnel, growth, and expansion. Photographs for these purposes are easily made ... they speak a universal language, clearly presenting actual conditions when even hundreds of words might be inconclusive. And medicolegally, properly-made photographs are specific, and readily understandable evidence.

INSTITUTIONS WITH PHOTO-GRAPHIC FACILITIES You are aware of the importance of a photographic department. To achieve the maximum benefit from it, however, the equipment must be kept up-to-date. Modernization of your department can be accomplished at very little cost which soon will be more than justified by increased efficiency.

When compared with the tremendous value of a photographic service, the cost is trivial. The profusely illustrated booklet, *Photography in Medicine*, tells the scope of medical photography and describes efficient equipment. Every hospital should have a copy.



How inadequate words alone would be to describe the progressive changes which these three simple pictures show so vividly. They are visible evidence—readily understandable, easily and economically obtained.

The coupon at the right is provided for your convenience in securing a copy of "Photography in Medicine." Fill in and mail it today.

ging: never have elieve '. As plan vacatakes y are

one extra emrally

near disyear and ared

put the ntil paso. uilt, ant ers

the

avs

ind

est

lay

em he

DS

eir

m

re

is

10

re

EAS	TMAN	KODAK	COMPANY,	Medical	Division
345	State	Street, I	lochester, N	. Y.	

Please send	me a free copy of the boo	oklet, "Photography in	Medicine."
Name			
Institution			
No. and Street			
City and State			

cleaning cloths around, we make ticking bags to hang in the ward kitchens. The maid puts her used cleaning cloths in the bag and, when she goes off duty for the day, brings the cloths to my office and all are sent to the laundry in one big ticking bag and returned to me the next day washed and ready to be given out. Ticking wears well and does not show the moisture from wet cloths."

Now let us see what vacation means to the housekeeper of a large medical center. A call upon Adelaide R. Maloney, head housekeeper at the Presbyterian Hospital in New York reveals the fact that she has no outside vacation relief. Extra help is engaged only in the event of the prolonged illness of an employe.

"The head housekeeper receives one month's vacation and one of the assistant housekeepers assumes this supervisory work along with her own work. The six assistant housekeepers each receive two weeks' vacation, none of which runs concurrently. They are trained to cover every phase the assistant housekeepers' positions.

"Maids and porters are given vacations of from six days to two weeks, depending upon the length of service. Each field is divided into sections and vacations are arranged to permit only one person to be absent from a section at a time. During the absence of an employe, the work schedule is rearranged to distribute the additional work and relief is sent from lighter sections.

of the department's activities, which

enables them to substitute in any of

"Our engineering department takes care of all repairs, painting and remodeling. The housekeeping department cooperates with it in the final cleaning and rearranging after its work is finished. The bulk of the painting is done during the summer.

"We take advantage of the lowered census during the summer months to do intensive cleaning such as wall washing; scrubbing and polishing of floors; washing, polishing and refinishing of furniture, and cleaning of rugs, drapes and curtains." • "Color Harmony in Rooms" was the title of an instructive talk given by a San Francisco interior decorator at the June meeting of the newly organized San Francisco chapter of N.E.H.A. This was the first of a series of talks on making rooms more attractive. At later meetings such subjects as "Selling Rooms by Giving Better Service" and "Selling Rooms by Improving the Morale of Employes" will be covered. The San Francisco chapter was organized April 28, with Florence Saunders of San Francisco's Hotel Whitcomb, as president.

• Valuable leather bindings on office records, research reports and books in the hospital library are less likely to crack and disintegrate if they are regularly treated with glycerine. The procedure is to wipe the leather surfaces lightly with a clean cloth dampened with glycerine, let it soak in a few minutes and then wipe it off with a dry cloth.

Similarly, other leather covered objects, such as chairs and desk accessories, may be preserved in their original supple condition.

- Porous stone and other material used in wainscoting corridors and entrance halls frequently acquire black streaks from shoes or from corridor traffic. To prevent this one housekeeper waxes the wall for a distance of 2 feet or more from the baseboard. Liquid wax is satisfactory for this purpose.
- If the rugs in the business offices or reception rooms curl up at the corners, this annoyance may be remedied by applying a glycerin paste to the back. This mixture is made by adding 5 parts of glycerin to 3 parts of starch, mixing them to form a smooth paste. Let the rug dry thoroughly before placing it on the floor.
- In cleaning an occupied private room in one of the large Chicago hospitals, the procedure for maids is as follows: Clean the rugs with carpet and vacuum sweepers three times a week or oftener if necessary. If the patient objects to the noise use the carpet sweeper only. Dust the floor; scrub it three times a week; dust all window sills, shields and furniture; change draperies and chair covers when they are soiled, and empty and clean wastebaskets. Report needed repairs to the housekeeper.

THE HOUSEKEEPER'S CORNER

• For the first time since the National Executive Housekeepers Association was formed more than seven years ago, a hospital housekeeper has been chosen to head the organization.

The new president is Doris Dungan, executive housekeeper at West Jersey Homeopathic Hospital, Camden, N. J., and co-editor of the housekeeping department of The Modern Hospital, who was elected at the fifth annual congress in Washington, D. C., last month. Mrs. Dungan succeeds Mrs. Adele B. Frey of Cleveland.

Officers elected to serve with Mrs. Dungan are Edythe Bussey, Pittsburgh, first vice president; Marion Wyatt, Chicago, second vice president, and Amelia Vossen, Philadelphia, national recording secretary. The national treasurer, Emily T. Barton, New York, and the national corresponding secretary, Marzita Haffner, Chicago, were reelected.

New members of the board of directors, named for three year terms, are Helen Graham, Marion Wyatt, Amelia Vossen and Bessie G. Best. Anne Owen, New York, former national president, was reelected to the board of directors and Cara Burnett, Mineral Wells, Tex., was elected to serve for one year.

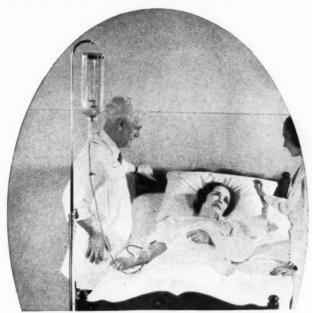
A general relief fund, to be available



Doris Dungan, executive housekeeper at West Jersey Homeopathic Hospital, Camden, N. J., is new president of the National Executive Housekeepers Assn.

for members who are ill, convalescent or unemployed, was set up by the organization, using the money that formerly had been designated as the thrift fund. Members agreed that this plan would give housekeepers a feeling of independence, since it can be used for emergencies. The fund is to be administered by the various chapters.

Life memberships were bestowed on three outstanding N.E.H.A. members, all past presidents of the organization: Margaret Barnes, Washington, D. C.; Grace Brigham, Providence, R. I., and Anne Owen, New York.



B A X T E R'S

DEXTROSE AND SALINE SOLUTIONS IN VACOLITERS

The final test . . . is the real test . . . of any intravenous solution

When you use them . . . that is the final, the real test of Baxter's Intravenous Solutions in Vacoliters . . . and in that final test they prove themselves fine and worthy every day. In your hospital, under your supervision, on your own cases, these fine Baxter's solutions show their ability to serve you and your patients . . . doing the work you want done, surely, satisfyingly, economically.

The laboratory purity of Baxter's so-

lutions is protected by the ingenious Vacoliters, safeguarded by metal, *sealed* from contamination and deterioration until you are ready to use them.

Be sure the solutions you use are passing the real test... at your patient's bedside. Be sure you are using Baxter's Dextrose and Saline Solutions in Vacoliters. They are pure, convenient, economical. They are the only ones with Vacoliter protection.

The fine product of

BAXTER LABORATORIES

GLENVIEW, ILL.

COLLEGE POINT, N. Y. GLENDALE, CAL.

TORONTO, CANADA

Produced and Distributed on the Pacific Coast by Don Baxter, Inc., Glendale, Cal.

Distributed East of the Rockies by



H.A. conble in

by a at the hized H.A. ks on later elling and the ered. rganders b, as

office is in y to

proaces ened nin-

dry

obces-

rig-

nce aks

To the

sat-

or

ers, by

ck.

5

ch,

te.

ore

ite os-

as

a

he

ıb

W

ge

ey

ne

L

Safeguarding the Milk Supply

MABEL G. FLANLEY

MILK has long been recognized as not only an essential food for persons of all ages but as a food with characteristics particularly suited to the feeding of the sick. It is well known that milk is a particularly perishable product, easily contaminated, and so warrants particular care in its selection, handling, distribution and service.

Is it not then a serious joint obligation of the purchasing agent and the dietitian of any hospital to know accurately the source of their milk supply? Should they not view most carefully their own methods of handling of milk to be assured that the institution permits no compromise with the quality and safety of the milk served to its patients and staff?

The first responsibility of the hospital is in determining the source of milk for its use. Fresh milk should be purchased with even more careful selection than other food products since it is more perishable in nature. It should come from the best available source so that its quality is unquestionable. Is this compatible with the frequent practice of purchasing milk by the competitive bid system? Yes, it can be but it too often is not.

If buying is the objective, not just bidding, then many factors other than price must be given due consideration. To know your milk company is the first essential. What is its standing with the local board of health; what are its own standards for quality; is it equipped to furnish you with the same high quality of milk all the year round, even during the period of low production; can it supply all the dairy products you may need, and will it assure you

New devices like this for filling cans make possible the delivery of milk that has not been touched by the human hand.



prompt delivery at a specified hour and adequate special delivery service to cover any emergency?

All these specifications being on an equal basis, then, and then only, can a bid be considered truly competitive and only then should price become the ruling factor. Low bidding may invite an entirely different quality; but for the hospital to extend such an invitation is inconsistent with its principles of sanitation.

A visit to the dairy plant to get first-hand knowledge of how the milk is handled by the company would seem a logical preliminary to the issuance of any purchasing contract, yet how many purchasing agents or dietitians have visited the dairies who bid for their business?

In many urban communities today most of the milk delivered exceeds the requirements of health authorities for both purity and richness. The responsibility of the distributor begins on the farm at the source of supply. Let us for a moment review what the discriminating purchaser should expect in the way of production, care and handling of a high quality fluid milk.

Many factors contribute to the present high quality of fluid milk. First, and perhaps most important of all, is the great improvement in both production methods and handling of milk on the farms. Improved feeding methods, frequent veterinarian inspection of herds, rigid regulations regarding construction and equipment of barns and milk houses, rapid cooling of milk on the farm and rapid transportation to the nearest receiving station, all make for a better quality milk.

Never at any time from farm to doorstep is the milk touched by human hand. In fact with the method in effect in most modern dairy plants today, the milk is never exposed to air from the moment it is poured by the farmer into the milk cans, which have been washed and sterilized and sealed for him at the receiving station. The lids of these sterilized cans are not lifted until

WHEAT, EGG, and MILK-FREE DIET For MILK-FREE DIET Date EGG-FREE DIET Date WHEAT-FREE DIET If you are sensitive to wheat alone, you may eat: Fats—Butter, meat, poultry or vegetable Breads-B or potato lergy Diets Cereals-Bar JUST THE WAY YOU WANT THEM Condiments Eggs—Baked co fried hard or lets, baked shirred

RY-KRISP Whole Rye Wafers

Note: Do no their preparat crumbs on shir omelets

R

duc-

nigh

the

nilk.

t of

oth

g of

ed-

ian

ons

iip-

ses,

rm arra

to

ıu-

od nts

to

ed

ns.

errese til

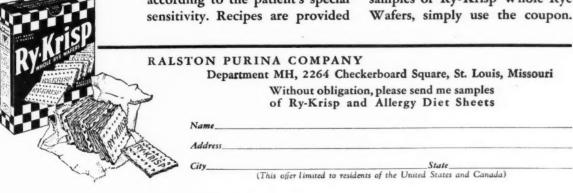
AL

Here's help that you've wanted for your patients and for yourself. Safe, accurate allergy diets printed on individual sheets and supplied to you in pad form. They're easy for the patient to follow-easy for you to use. All you need do is fill in your patient's name, your name and special instructions.

Prepared with the cooperation of leading specialists, these sheets list exactly what foods may be eaten and which must be avoided according to the patient's special on the back. No advertising appears on them.

Naturally Ry-Krisp is included among the allowed foods-for these crunchy, wholesome wafers, so simply made of whole rye, salt and water, are both safe and delicious. In fact, they actually encourage the patient to adhere more closely to the necessary diet-because they taste so good with other foods at every meal.

For copies of these sheets and samples of Ry-Krisp Whole Rye





Sterilized bottles emerge from the machines in this huge pasteurization plant, are examined by the inspector and pass by conveyor to apparatus that automatically fills and caps them at the rate of 120 each minute.

from each farm is tested, to be assured that it meets the quality standards of the company, then it is weighed and cooled, after which it passes through stainless steel equipment to waiting tank trucks or tank cars which transport it to the city pasteurizing and bottling plant.

the moment the farmer fills them.

At the receiving station, the milk

These tank trucks and cars are lined with either glass or stainless steel and are so well insulated that the temperature of the milk does not change so much as one degree though the journey to the city may

At the city plant the milk is tested again before it is accepted. Then begins the flow of endless streams of milk through stainless steel equipment to the pasteurizing, cooling, bottling and filling processes.

be as far as 300 or 400 miles.

From huge bottle washing machines in a modern plant sterilized bottles are carried by conveyors to the bottle fillers. Each individual bottle has been subjected to twenty-two minutes of washing, cooling and sterilizing before it emerges in glistening cleanliness from the discharge end of this great machine. Here again the bottles are scrutinized for any possible defect by attendants working under powerful revealing lights before the bottles pass on to the filling machine.

The cans in which some of the milk is supplied to institutions and

hospitals are subjected to a similar washing and sterilizing process by the can washing machine. Then these cans are filled in a special room. After filling, the bottles or cans are carried by conveyor to the chillroom where they are held until delivery.

In the early hours of the morning the huge wholesale trucks line up at the loading platforms, the cans



Cans of milk that have been stored in the chillroom are loaded directly onto insulated trucks.

and cases of milk pass directly from the chillroom to the insulated trucks and are off to their final destination. The trucks servicing hospitals and institutions are dispatched with the regularity of a railroad schedule.

No hospital is more meticulous in cleanliness than the modern dairy, More than one-third of the total work hours in the plant is devoted to cleaning. Each piece of equipment is taken down, thoroughly washed, scrubbed and sterilized after each use. All milk piping is in sections so that it is readily detachable for cleaning. After the cleaning is completed, the apparatus and equipment are reassembled and sterilized with boiling water and steam. Again, just before being used the following day this sterilization is repeated, a double precaution to safeguard the

During every step of the processing and distribution of milk, laboratory supervision is exercised. A sample bottle of milk is removed every half hour during the operation of each plant and checked by the laboratory. Samples are also taken from retail and wholesale delivery trucks, brought to the laboratory and checked for bacterial content to be sure that the high quality is maintained until the very moment the dairy must relinquish its responsibility, at which time the milk is delivered to the institution.

With the milk delivered into the receiving room of the hospital, the institution assumes responsibility. Complete familiarity with the care and precision of the handling prior to this point will and should make the dietitian extremely critical of the methods within her own institution.

First of all, is she accurately informed regarding the different grades of milk available? Does she judge the grade only by the butter fat content or does she give due consideration to the extra care in production and the much more rigid laboratory control exercised over the higher grade? Is she letting the same appreciation of quality that guides her in the selection of canned goods guide her in determining what milk she shall buy?

In most metropolitan areas now the sanitary code governing the milk supply prohibits the sale of bulk milk, except for cooking purposes, unless that milk is dispensed direct

BASIC OPERATIONS IN COMMERCIAL CANNING PROCEDURES

V. HEAT PROCESSING THE SEALED CONTAINER

• Previously, we have described how raw food material is sealed in the tin container after proper preparatory treatment. After sealing, the next important step in commercial canning is the heat process, or "process" as it is called in the industry.

from trucks nation. Is and the the

ous in dairy.

total evoted equipoughly

l after n secchable

ng is

equip-

ilized

gain,

wing

ed, a

d the

ocess-

bora-

every

n of

labo-

from

ucks,

and

o be

nain-

the

onsi-

de-

the

the

ility.

care

rior

iake

the ion. in-

rent she

tter

con-

orogid the

me

des

ods

iilk

ow nilk ulk ses, ect

AL

Essentially, the processing operation involves exposure of the sealed container to hot or boiling water, or to steam under pressure, for the correct period of time. The purpose of the process is to destroy pathogenic or spoilage organisms which may be present on raw food material; the seal on the can then prevents re-infection of the foods by such organisms. Thus, the sealing and processing operations combine to insure a sound, wholesome canned product.

It is not possible here to review all factors which must be considered in the establishment of an adequate heat process for any specific product. Such factors have been briefly discussed in recent publications (1, 2). It must suffice to state that, in general, commercial processing operations are divided into two general types, depending upon the acidity of the food being canned.

The "acid" foods—including the common fruits and certain vegetables or vegetable products whose pH values fall below 4.5—are quite easily heat processed. With such foods it is only necessary to heat the sealed container long enough to permit the attainment of a definite temperature

in the center of the can (usually 200°F. or slightly less). In fact, some acid products may be processed by filling sufficiently hot, sealing and inverting the cans, and cooling without further process.

The "non-acid" foods—such as meat, sea foods, milk and most of the common vegetables—require temperatures above that of boiling water for adequate heat processing. Such foods are processed under steam pressure in a closed "retort", usually at a temperature of 240°F. Years of research have made possible the issuance for the guidance of modern canners of a bulletin listing recommended process schedules for the non-acid products (3).

Regardless of the temperature of processing, equipment is available which permits use of the batch or "still" process, and the "continuous" or "agitating" types of process for sealed cans. Improvements in processing machinery and accessory instruments during the past two decades permit precise, scientific control of commercial processing operations.

Above all, however, the modern canner has a clear understanding of the underlying purpose of the process and a deep appreciation of the necessity for strict supervision of the processing operation. Commercially canned foods, consequently, must be ranked today among the most wholesome foods coming to the American table.

AMERICAN CAN COMPANY

230 Park Avenue, New York, N.Y.

(1) 1938 Food Research 3, 13.

(2) 1937. J. Amer. Med. Assn. 109, 1046.

(3) 1937. Natl. Canners Assn. Bull. 26L, 3rd ed.

This is the thirty-eighth in a series of monthly articles, which summarize, for your convenience, the conclusions about canned foods reached by authorities is nutritional research. We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association. to the consumer for consumption on the premises where it is dispensed from a mechanical device satisfactory to the board of health. Such a device must be washed, sterilized, filled and sealed at the pasteurizing plant after filling. The only exception to this regulation is made when the board of health issues a certificate of exemption to a hospital or other institution.

This imposes a serious trust upon the hospital management; perhaps, in many instances, a trust that inadequacies of equipment and personnel make it difficult to fulfill.

Will not the near future bring serious consideration of whether or not it is logical for a hospital, upholding the finest sanitation standards, to endanger its standing by assuming what is a known risk—the dispensing of bulk milk for fluid consumption? Does this not savor in too many institutions of a possibility of careless handling of a perishable and easily contaminated product?

Most modern hospitals today have good refrigeration for dairy products, a separate refrigerating room kept at a temperature between 38° and 45° F. This room should have sanitary walls which can be hosed down, preferably with steam. The sterilization of containers, the temperature and sanitary aspects of the room in which they are filled, the avoidance of the dip method of dispensing, the proper agitation of milk so that each portion will have a uniform butter fat content, the storage in serving pantries, all must be controlled. Some hospitals have avoided the ills of the dip method of dispensing by installing especially constructed urns in all serving pantries, into which the milk may be poured from the 40-quart can in which it comes from the dairy. Adequate sterilization of this equipment then is the main problem.

At regular intervals most hospitals make bacteria counts and butter fat tests on their milk supply to be certain that the standard is maintained by the dairy company serving them. It would also seem good practice for the hospital to emulate the reputable dairy and make tests at its last point of responsibility—the glass of milk on the patient's tray or nurses' table. Bacteria counts and butter fat

determination at this point would

be an indication of the adequacies or inadequacies of control of the milk within the institution. luncheon dish, potatoes, vegetable, salad and dessert. In addition, the patients may make selections from the à la carte suggestions at the bottom of the sheet. These suggestions feature foods that are easily prepared and that are available at the time.

Soon after the patients are admitted to the ward they are visited by a dietitian who teaches them how to order their meals. Each morning a diet maid distributes the menus for the following day and later collects them. They are taken to the dietitians' office where all the food items ordered are entered on summary sheets. After the requisitions for food have been written from these sheets by a dietitian, they are posted in the central serving unit to be used as work sheets by the maids who put the food on the trays.

WESLEY MEMORIAL HOSPITAL

Monday Name May 30 1938 Room LIGHT SOFT

Breakfast

Pineapple juice Ralstons Eggs Sliced oranges Shredded wheat Bacon

Bread

Luncheon

Puréed vegetable soup

Rice and tomatoes Stuffed baked potato Peach salad Fruit perfection salad Cherry upside-down cake Junket

Bread

Dinner

Celery stock soup
Escalloped potatoes
Carrots, brown sauce
Grapefruit salad

Gelatin

Mashed potatoes Buttered spinach Lettuce salad Ice cream

Bread Bev.

A la Carte

Bread: white, rye, whole wheat

Beverage: coffee, milk, tea, cocoa, tomato juice

Main Dish: cottage cheese, egg, bacon Vegetable: baked potato, green beans Dessert: custard, pineapple, apricots

Please Check Food Desired Patients on light diet may order any food on this sheet.

Patients on soft diet may order any food which is italicized.

In striking contrast to the patients in private rooms, those in the ward exhibit little curiosity or spirit of adventure in the selection of their food. They usually select simple familiar

Selective Ward Menus

ELIZABETH H. TUFT

A RECENT advance in hospital food service has been the introduction of a selective menu for private room patients. This type of service has been developed in a great many institutions and its use has been generally approved. One of the next steps will be the adoption of the selective menu for ward patients.

The need for curtailing the per meal cost of feeding this low revenue group at Wesley Memorial Hospital, Chicago, made us hesitate to initiate a change in the food service which, even though desirable, might prove to be more expensive. However, it soon became apparent that, instead of increasing the cost of food, the use of a selective menu was actually decreasing the costs.

A comparison of the figures covering the four month period since the

plan was introduced with those of the preceding four months shows that the average food cost per meal is \$0.013 lower during the latter period. The per meal cost of the personnel dropped only \$0.009 during the same months.

According to our plan, two selective menus are written for the ward patients, one for those on general diet and one for those on light and soft diets. On the light diet menu the foods allowed on the soft diet are italicized. By using foods featured on the cafeteria menu and some of the items from the private room menu, it is possible to provide considerable opportunity for selection without materially increasing the number of foods to be prepared.

A choice is usually listed for the breakfast fruit and cereal, main

"Put your kitchen expenses on a FIXT diet"

etable, n, the

from ne botestions

epared me.

e advisited n how

orning ius for ollects dieti-

items

nmary

is for

these posted

e used

no put

ITAL

ranges

wheat Bacon

potato n salad unket

tatoes

oinach e salad

cream

a, to-

bacon beans

r any

r any

tients

ward of ad-

food.

niliar

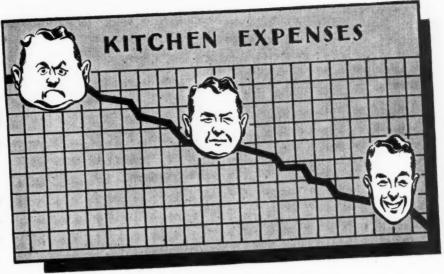
PITAL

Watch costs go down . . . because every necessary ingredient is already in FIXT all-fixed Ginger Muffin Mix.

Today, x-ray your kitchen x-penses thoroughly. Check how many different bills you pay ... how many different ingredients you order ... to make one serving of ginger muffins. Then compare with the convenience of FIXT all-fixed GINGER MUFFIN MIX ... all the ingredients in one package ... nothing to do but add water and bake.

No wonder FIXT is failure-proof. Even inexperienced help can't muff the way to perfect ginger muffins.

FIXT is produced by the world's largest makers of ready-mixed foods. Each ingredient is top-quality. Each kitchen is hospital clean. So decide now to save money and to safeguard the reputation of your institution for fine food. Order some FIXT GINGER MUFFIN MIX



from your local jobber. Or write us direct. We will be glad to give you full information also about other FIXT all-fixed Mixes for waffles, corn muffins, devil's food cake, white cake, handy doughnut, yellow cake, pie crust, egg griddle cakes, buckwheat cakes, and biscuits. Write now!

Write Dept. MH-7 for valuable FREE booklet, "76 FIXT RECIPES" FIXT Products, 1170 Broadway, New York, N. Y.



SUNFILLED 66 3 C Gal.

Made from SUNFILLED Brand Orange Concentrate which retains to a very high degree the color, flavor, vitamin content and food values of the fresh fruit juice.

A 10 to 1 orange concentrate—just the water taken out and nothing added—no sugars, acids or preservatives. Return the water—9 parts to 1—and the natural flavors and food elements of the fresh fruit juice are reproduced in high degree.

Hospital Administrators and Dietitians use SUNFILLED Brand Orange Concentrate to advantage. It is pure. The quality is constant. Is easily prepared—add the water and serve. Saves refrigeration space and freights. There is no waste. The cost per gallon of juice is low and will not fluctuate. A reliable source of supply at all times.

Fill in the coupon for more complete information.

Hospital	***************************************
Attention of	

CITRUS CONCENTRATES, INC.

DUNEDIN, FLORIDA, U. S. A.

Buffalo Office: 220 Delaware Avenue

New York Office: 545 Fifth Avenue





This Seal of Acceptance denotes that SUNFILLED Brand Orange and Grapefruit Concentrates and advertisements for them are acceptable to the Council on Foods of the American Medical Association.

dishes in preference to those involving more elaborate preparation and unusual combinations. For example, custard or junket is more popular than Bavarian cream, lettuce or tomato salads are ordered more frequently than combination vegetable salad and cottage cheese is preferred to almost any casserole dish.

There are several distinct advantages in the selective food service. First, and of the most importance, is the reduction in waste. The per meal weight of edible food left on the trays has been reduced approximately 0.3 ounce since the change was inaugurated.

This saving has been made because patients are no longer served food that they do not care for and because those with poor appetites usually select only a few items on the menu or request small servings. Women frequently mention that they prefer to specify the exact quantities desired because they are then relieved of the worry of wasting wholesome food.

Another advantage results from the method of handling the special diets made possible by the use of the selective menu. When patients are placed on therapeutic diets they are instructed regarding the amount and types of food allowed and are taught how to check their menus in conformity with these dietary restrictions. Their menus are corrected by a dietitian and, if errors are noted, further instruction is given.

This plan not only saves the time that would be required for a dietitian to write all the special diets but also gives the patients the experience of writing their own menus under supervision during their entire stay.

Persons who have strong food prejudices or idiosyncrasies or who closely observe religious and racial customs are always difficult problems in an institution. By allowing them the privilege of planning their own meals, they are better satisfied and are more certain to obtain an adequate diet. Computation of the food values of many menus has shown that they are surprisingly well balanced. Even the men who frequently omit salads and vegetables include extra fruit, which compensates for the omission.

Undoubtedly the best argument in favor of the plan is the response of the patients. The fact that their preferences are given consideration makes them realize that the personnel of the dietary department is interested in them as individuals and is trying to make their stay pleasant.

Aseptic Dishwashing

The methods for dishwashing and dishwashing equipment in Chicago hospitals have not been subject to inspection by the Chicago Board of Health in the past. This condition seems to exist quite generally throughout Illinois. With more rigid regulations for maternal and infant care, with the careful inspection of all plumbing once a year, it is likely that hospital dishwashing will come in for its share of inspection and regulation, according to a recent issue of the *Bulletin* of the Illinois Dietetic Association.

Since most modern hospitals are equipped with mechanical dishwashing machines, the dietitian is most interested in heat as a disinfecting agent in dishwashing. Regulations state that somewhere during the washing or rinsing process the temperature shall be 170° F. for one minute. This means that the dishwasher must be equipped with a thermometer.

Washing dishes at a temperature of 170° F. will tend to cook the food particles on the dishes so that the dishes do not come out of the dishwasher clean. Dishwashing compounds may be broken down at this high temperature. A temperature of 140° to 145° F. is recommended for the washing processes. If the water coming from the hot water supply is above this temperature a thermostatic control can be installed on the wash tank so that when the water reaches too high a temperature in the wash tank cool water is run in.

It is recommended that the rinse water be 170° F. or higher. If the rinse water does not reach this mark, it may be necessary to install a temperature booster in the rinse water line.

Since temperature control is so important in dishwashing, a two tank machine, one for washing and one for rinsing, is most efficient for a volume of work. Instead of washing dishes in each unit many hospitals transport the dishes to a central dishwashing room where a two or a three tank machine can be used.

For the proper washing of pots and pans a three compartment sink is necessary for soaking, washing and rinsing.

Dressing Up Frozen Desserts

A score of ways to give palate appeal to ice creams and ices:

Vanilla Pitted fresh or canned cherries

Chopped preserved ginger and syrup Cooked or canned prunes and syrup

Cooked or fresh fruit

Peanut brittle melted in hot water

Between cake slices with hot fudge sauce or with canned or fresh fruit sauce

On sponge cake slices, topped with peach halves and

vanilla or crushed raspberries

Honey or hot maple syrup

Butterscotch patties melted in hot water Chocolate mints melted in hot water

Toasted shredded coconut

On sponge cake with honey or salted nuts

On waffles with hot maple syrup

Vanilla or Crumbled macaroons
Coffee Hot chocolate sauce

Hot chocolate sauce with marshmallow Topped with grapes and diced oranges

Whipped cream with grated orange rind

Vanilla or Raspberry Ice Orange and Pineapple Ice

Orange Ice

Chocolate

Cantaloupe halves

With crushed raspberries or strawberries



ng

and cago

d of

ition 11 y nore

and specir, it hing specto a the

are ashnost ting ions the emone

ish-

n a

ure

ood

the ish-

omthis

of

for

the

iter

e a

led

the

ure

is

nse

the

rk,

m-

ter

SO

VO

nd

or

h-

)S-

a

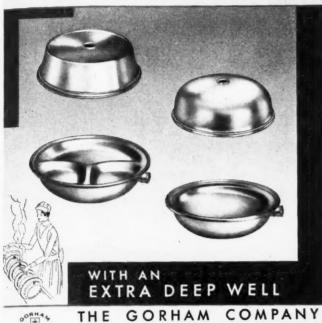
2

n

ots nk

ıg

L



New York,

6 W. 48th St.

HOSPITAL DIVISION

Chicago, 10 S. Wabash Ave. San Francisco,

972 Mission St.



No extravagant claims—no special blend for you alone. But coffee priced right that is going to please your patrons and increase your business. Backed by 55 years experience in supplying hotels and restaurants. John Sexton & Co.-Chicago-Brooklyn

SEXTON QUALITY FOODS

KITCHEN-HOT FOOD TO EVERY PATIENT

Served Economically with



Odeal
FOOD CONVEYOR SYSTEMS
Found in Ferencest Hospitals





MEALS in institutions equipped with Ideal Food Conveyor Systems are served hot, always on the dot! Even the rooms farthest from the kitchen can be served with appetizing, nourishing, kitchenhot foods without delay or trouble.

Ideal Food Conveyors transport entire meals from kitchen to floors with almost magic ease and efficiency. New temperature controls preserve food flavors and moisture, new construction features—never before used in food conveyor systems—make service easy and quick.

Leading hospitals throughout the country have used Ideal Food Conveyor systems for many years, have found them labor-saving and money-saving. Tens of thousands of kitchen-hot meals from these

WRITE FOR NEW CATALOG

A new line from the foremost manufacturer of food conveyor equipment! Write today for this big catalog containing new ideas in scientific food service! finer food conveyors each day prove that Ideal Food Conveyor Systems are the finest for hospitals and institutions!

Learn how Ideal Food Conveyor Systems can solve your food service problems.



THE SWARTZBAUGH MFG. CO. TOLEDO, OHIO, U.S.A.

Established in 1884

Distributed by The Colson Corp., Elyria, Ohio.

Branches in principal cities.

Brioche of Kennebec Salmon a la Russe



This attractive dish is recommended for special occasions. The recipe consists of two parts: (1) preparation of the brioche and (2) preparation of the salmon. The recipe is given in detail in the adjoining column.—Ernest Piron, executive chef, Hotel Gibson, Cincinnati.

Private Dinner Trays

Entrée tray includes tomato juice cocktail, grilled lamb chops, baked potato, acorn squash, grapefruit and watercress salad, assorted breads and butter. On the soup tray are cream of spinach soup and toast sticks. The dessert tray includes chocolate éclairs and coffee. — Prepared by Adeline Wood, supervising dictitian, Mount Sinai Hospital, New York.

Brioche of Salmon

Ingredients for the brioche are 13 ounces of flour, 8 ounces of butter, 1 ounce of yeast, ½ cup of milk, a pinch of salt, ½ ounce of sugar, 4 whole eggs and 4 egg yolks.

eggs and 4 egg yolks.

Dissolve the yeast in lukewarm water; melt the butter. Sift all dry ingredients into a large mixing bowl, add eggs and yolks, butter, yeast and milk and mix thoroughly with a large spoon for about fifteen minutes. Set aside in a warm place to rise.

Ingredients for the salmon are ½ pound of fresh Kennebec salmon, ½ pound of fresh halibut, 6 fresh mushrooms, ½ onion, 1 tablespoon of chopped parsley, 1 teaspoon of chopped chives, 2 hard boiled eggs, a pinch of salt, a dash of paprika, a pinch of allspice, a pinch of nutmeg, ½ glass of cream, the white of 1 egg and 1 tablespoon of blanched pistachio nuts.

Cut the salmon lengthwise, remove the bones and set aside. Make a mousse of fish by pounding the halibut very fine and straining it through a sieve. Then put it in a saucepan and place it on ice. Add the white of egg to the mousse, season with a little salt, paprika, allspice and nutmeg and mix in the cream slowly.

Chop the onion very fine and sauté it in butter in a skillet; add the mushrooms cut in thin slices. Cook for a few minutes and set aside to cool. Mix the onion and mushrooms with the mousse, add the chopped parsley, chives and pistachio nuts.

As soon as the dough rises, mix again and put half of the dough in a buttered pan. Place the salmon on top of the dough, the mousse on top of the salmon, and the hard boiled eggs, cut in slices, on top of the mousse. Place the rest of the dough over all and leave in a warm place to rise. When it is risen sufficiently, put it into the oven and bake slowly for forty-five minutes. Remove the brioche from the pan and place it on a large platter for serving.

Garnish with segments of lemon and parsley and serve with a crisp salad.

Pear Macaroon Salad

Fifty Servings

Philadelphia cream cheese 100 canned pear halves 4 cups macaroon crumbs 50 lettuce leaves 50 maraschino cherries Mayonnaise

Slightly soften the cheese with a small amount of milk. Spread a layer between two halves of pear. Dip the whole pear in macaroon crumbs. Place on crisp lettuce and garnish top with cherry. Serve with mayonnaise.

TIME TO EAT!

ONE OF THE **IMPORTANT MOMENTS** IN THE MAINTENANCE

e 13

er, 1 oinch

vhole

varm dry

lwoo and arge

Set

2 1/2 , 1/2

ush-

of

pped h of

alls of

ableove

e a ibut h a

and

egg

salt,

mix

auté ush-

or a

Mix

the

ley,

mix

n a

top the

cut ace

ave

is

ven

tes.

ind

ng. ınd

er he

ce

th

L



of HOSPITAL REPUTATION

Convalescing patients have nothing to do but eat! Their off-normal appetites are delicate and fussy. TASTE is important to them. And it's important to you! If your discharged patients rave to friends about the "wonderful meals"-you're building good-will far and wide!

Modernize your kitchen with Vulcan Gas Cooking Equipment and improve the taste and flavor of the same foods you serve today.

Save money, too. Such Vulcan features as Automatic Heat Control, Ceramic Broilers, Radial Fin Cooking Tops not only bring out top-notch flavors in foods-they save gas-reduce meat shrinkage-prevent food spoilage.

Modern features have been perfected since you installed the equipment you now have. Write for-"Cutting Cooking Costs.

Hospital Division

STANDARD GAS EQUIPMENT CORPORATION

18 East 41st Street, New York

Chicago Baltimore Aurora, III. Los Angeles Philadelphia New Orleans



Your Chef is a true artist who works better when his equipment aids him with scientific control. He'll be proud of such sparkling Vulcan Gas Equipment as you see in this typical hospital installation. It's compact, easy to clean.



KELLOGG'S RICE KRISPIES ARE LIGHT AND EASILY DIGESTED

THEY MAKE A CRISP. **DELICIOUS BREAKFAST,** LUNCH, OR BEDTIME SNACK





Crackles IN CREAM

Kellogg's Rice Krispies is a ready-to-serve cereal enjoyed by patients and personnel alike.

These tasty, toasted rice bubbles are so light, wholesome, and easy to digest that they're ideal for convalescents' diets . . . so crisp and delicious that every one likes to see them on the menu.

Children, especially, love to hear Rice Krispies snap-crackle-popping in milk or cream. That cheerful sound amuses young patients, and "perks up" lagging appetites.

In individual packages, Rice Krispies are convenient and economical. Made by Kellogg in Battle Creek.

August Dinner Menus for the Small Hospital

Eleanor McCarthy Dietitian, Charles Godwin Jennings Hospital, Detroit

Day	Soup or Appetizer	Meat	Potatoes or Substitute	Vegetable	Salad or Relish	Dessert
1.	Consommé	Roast Beef au Jus	Browned Potatoes	Buttered String Beans	Carrot and Raisin Salad	Angelfood Cake
2.	Tomato Bouillon	Lamb Chop With Mint Jelly	Parsley Potatoes	Braised Celery	Gingerale Salad	Charlotte Russe
3.	Cream of Corn Soup	Leg of Veal With Currant Jelly	Buttered Noodles	Buttered Peas	Lettuce Roll Salad	Peach Tart
4.	Scotch Broth	Swiss Steak	Creamed Potatoes	Buttered Asparagus Tips	Mexican Slaw	Chocolate Sundae
5.	Cream of Mushroom Soup	Baked Trout With Lemon Butter	Baked Potatoes	Grilled Tomatoes	Fresh Fruit Salad	Apricot Upside-Down Cake
6.	Orange Blossom Cocktail	Calves' Liver and Bacon	Escalloped Potatoes	Buttered Spinach	Molded Grape Salad	Apple Brown Betty
7.	Chicken Noodle Soup	Roast Chicken With Sage Dressing	Mashed Potatoes	Braised Carrots	Tomato Aspic Salad	Butterscotch Sundae
8.	Cream of Pea Soup	Tenderloin Steak With Catsup	French Fried Potatoes	Diced Beets	Grapefruit and Cherry Salad	Fruit Gelatin
9.	Jellied Consommé	Baked Ham, Raisin Sauce	Candied Sweet Potatoes	Swiss Chard	Banana-Nut Salad	Pineapple Sherbet
10.	Cream of Tomato Soup	Breaded Veal Cutlet	Baked Stuffed Potatoes	Buttered Lima Beans	Lettuce Slaw	Pumpkin Tart
11.	Vegetable Soup	Leg of Lamb, Mint Sauce	Buttered Rice	Braised Parsnips	Waldorf Salad	Lime Marlowe
12.	Cream of Spinach Soup	Haddock, Tartare Sauc	e Parsley-Butter, Potato Balls	Stewed Tomatoes	Golden Glow Salad	Washington Pie
13.	Beef Broth	City Chicken	Shoestring Potatoes	Mashed Rutabagas	Orange and Date Salad	Spice Cup Cake
14.	Chicken Broth	Chicken Fricassee With Dumplings	Potato Puffs	Creamed Peas	Royal Salad	Marshmallow Sundae
15.	Cream of Mushroom and Spinach Soup	Perch With Lemon	Riced Potatoes	Buttered Cauliflower	Head Lettuce Salad	Jelly Roll
16.	Tomato Juice	Lamb Pattie With Pineapple Fritters	Creamed Potatoes	Braised Celery	Macedoine Salad	Apricot Tart
17.	Pepper Pot Soup	Beef Stew	Boiled Potatoes	Diced Carrots, Boiled Onions	Melon Cooler Salad	Baked Apple
18.	Vegetable Soup	Roast Veal	Browned Potatoes	Harvard Beets	Pineapple, Celery and Nut Salad	Chop Suey Sundae
19.	Cream of Pea Soup	Salmon Steak	Escalloped Potatoes	Buttered Spinach	Coleslaw	Snowballs, Apricot Sauce
20.	Jellied Consommé	Meat Balls	Buttered Noodles	Baked Squash	Tomato Salad	Apple Tart
21.	Chicken Gumbo Soup	Roast Turkey With Dressing	Mashed Potatoes	Buttered Asparagus	Beet and Egg Salad	Lemon Ice
22.	Cream of Potato Soup	Lamb Chop With Mint Jelly	Buttered Rice	Buttered Peas and Celery	Lettuce Roll Salad	Devils Food Layer Cake
23.	Beef Broth	Veal Birds	Baked Stuffed Potatoes	Creamed Onions	Apple and Date Salad	Prune Whip
24.	Fruit Juice	Baked Pork Chop	Parsley Potatoes	Grilled Tomatoes	Spiced Pear and Jelly Salad	Steamed Carrot Pudding Hard Sauce
25.	Consommé	Ragout of Beef	Hashed Brown Potatoes	Buttered Broccoli	Macedoine Salad	Chocolate Sundae
26.	Cream of Tomato Soup	Broiled Whitefish, Tartare Sauce	French Fried Potatoes	Mashed Rutabagas	Fruit Salad	Gelatin, Custard Sauce
27.	Melon Ball Cocktail	Lamb Stew	Boiled Potatoes	Braised Carrots	Asparagus and Tomato Salad	Cherry Tart
28.	Chicken-Rice Soup	Fried Chicken	Potato Puffs	Creamed Cauliflower	Brazilian Salad	Peppermint Stick Ice Cream
29.	Barley Soup	Tenderloin Steak	Baked Potatoes	Buttered String Beans	Lettuce Slaw	Pineapple Upside-Down Cake
30.	Cream of Corn Soup	Ham and Escalloped Potato Casserole		Harvard Beets	Peach Cup Salad	Angelfood Cake
31.	Fruit Juice	Fillet of Sole With Lemon	Parsley Potatoes	Buttered Lima Beans	Cauliflower Salad	Plum Pudding

Recipes will be supplied on request by Anna E. Boller, The Modern Hospital, Chicago.

As ma mo

E

a s is c tio

vii C

in

More Vitamin C in Orange Juice When Made With New Extractor

JUICE YIELD ALSO RAISED-EXTRACTING TIME SHORTENED

As MUCH as 12% to 23% more vitamin C is now made available in fresh orange juice—the foremost dietary source of the anti-scorbutic factor. An improvement in extracting equipment is responsible.

It is an oscillating strainer, incorporated

in the new model Sunkist Extractors. The juice, forced vigorously through a series of slots and holes, is enriched with edible portions of the fruit heretofore discarded.

dae

Cake

udding,

auce

own

ITAL

Vitamin C Yield Near Maximum

Repeated analyses show that this method extracts virtually all of the vitamin C contained in the edible

portion of the orange-from 12% to 23% more than other methods such as pressure squeezing.

The *volume* of juice is also increased through inclusion of more solids. Simultaneous extracting *and* straining saves time and minimizes the

difficulty of providing patients with really fresh orange juice at peak hours.

Rich Peripheral Areas Reached

Vitamin C is found in highest concentration towards the periphery of the orange. Power reaming dislodges the outer juice sacs along

with the albedo for further shredding in the oscillating strainer. Being water-soluble, the vitamin C (ascorbic acid) is more completely leached out into the strained juice, providing a richer concentration of this important therapeutic food essential.



Investigate the ability of the new Sunkist Extractor

to give more and richer juice from oranges in less time. Priced at only \$54.95, f.o.b., Chicago, Ill.

Ask your supply house for a demonstration, or write California Fruit Growers Exchange, Sunkist Building, Los Angeles.

Copyright, 1938, California Fruit Growers Exchange





Monthly News Review

Doctors Attack Hospitals for Giving Special Services; Goldwater Replies

A broad frontal attack upon all hospital services, excepting only the provision of bed, board, ordinary nursing, ordinary medication and the use of the hospital's physical facilities, is being made by the Philadelphia County Medical Society and the Pennsylvania State Medical Society.

The two medical associations have objected to the issuance of a charter to the Associated Hospital Service of Philadelphia, a hospital care insurance plan that proposes to provide substantially the same type of benefits that are provided by approved plans in Baltimore, New York, Cleveland and other

communities.

The medical groups have gone further than this, however. The attorneys for the medical societies apparently are prepared to argue that it is illegal for a hospital to provide a patient with any service which involves the services of a physician and that existing practices of hospitals in providing these services to ward and private patients are, and have been, in violation of the laws of the state.

Service Plan is Approved

The incorporators of the Associated Hospital Service applied for a charter on May 23 to the court of common pleas No. 7 of Philadelphia. Their application had been approved by the state commissioner of insurance. Furthermore, their plan of organization had previously been approved by the Philadelphia County Medical Society, as reported in the news columns of The Modern Hospital for April:

After having approved the plan, the medical society abrogated its agreement, stating in the "Weekly Roster and Medical Digest" that the plan was not legal under the nonprofit insurance act and that it "nullified the safeguards against the sale of medical services by the hospital or corpora-

tion.'

After obtaining legal advice locally and from the American Medical Association, a resolution was prepared stating that the plan places the hospitals in the position of corporations practicing medicine contrary to law and to sound public policy.

A conditional concession was made by the society in connection with clinical laboratory services. These can be provided with the society's approval if they are ordinarily performed by a technician or intern.

The two judges of the court of common pleas have appointed Arthur E. Weil, a Philadelphia lawyer, as master to examine evidence and report his recommendation on the charter.

Dr. William Egbert Robertson, president of the medical society, has resigned as one of the incorporators of the Associated Hospital Service. Both sides have employed counsel.

Challenges Medical Societies

In a public statement to the A.H.A. council, Dr. S. S. Goldwater, New York City commissioner of hospitals, sharply challenged the contention of the national and local medical societies. The usefulness of the leading hospitals of the United States would be seriously impaired if these proposals are adopted, Doctor Goldwater declared. The society erred, he said, in failing to distinguish between the art of medicine and transactions of a purely business nature that are incidental to medical practice but not of it.

He defended the desirability of salaries for laboratory experts under certain circumstances and pointed out that professional rights and privileges are granted to physicians by the public for the public's own protection and not to

foster a monopoly.

"Hospital care divorced from diagnosis and treatment is inconceivable, but no institution can actually 'diagnose, treat, operate or prescribe.' Making a diagnosis or ordering or administering treatment is a personal act involving judgment, manipulation, skill. Medicine is practiced in a hospital, never by a hospital."

Doctor Goldwater declared that it is impracticable to carry on the work of a modern general voluntary hospital with a completely uncompensated staff.

"If the employment of a physician by a hospital for any medical purpose is the practice of medicine by the hospital, the federal government, every

(Continued on page 98)

Jersey Center Will Erect 14 Story Hospital School for Housing 500 Children

A 14 story hospital school to provide accommodations for approximately 500 children will become another unit in the Jersey City Medical Center. The hospital school will house temporarily needy children while their parents are away from home either for medical treatment or in penal institutions. The children will be given instruction by competent teachers and also any treatment necessary to correct physical defects. A modern day nursery also will be provided.

A chapel, waiting and visiting rooms, administration quarters and classifica-tions rooms will occupy the first floor of the new building. The second floor will be a complete school unit, with library and auditorium, while the third floor will be devoted to kitchen and

dining room space.

The fourth, fifth and sixth floors will contain single rooms for girls and large recreation rooms. Accommodations for surgical operations will be located on the seventh floor, and on the eighth will be a children's hospital.

The ninth will be the "family floor."

Hospitals and Insurance Plans Under Fire at A.M.A. Meeting

By two resolutions at its annual convention in San Francisco last month the American Medical Association sought to keep medical services beyond the control of hospitals and organizations providing hospital care insurance to groups of individuals.

One resolution authorized the association to withdraw its approval of hospitals providing special medical services such as anesthesia, laboratory diagnosis and x-ray work to patients who paid only through fees to some health insurance organization.

The other specified that association approval of hospitals might be withdrawn in cases in which the insurance group hired the physician in addition to paying for the hospital care.

Dr. Rock Sleyster of Wauwatosa, Wis., a psychiatrist, was chosen president elect. St. Louis was named as the convention city for 1939, New York for 1940 and Cleveland for 1941.



TRUE TO THEIR TRUST

ILLY AMPOULES have been an important factor in the advancement of hypodermic medication. They provide accurate doses of carefully tested solutions ready for prompt administration. For sterility, uniformity, and absolute purity, specify "Lilly" on all ampoule orders and requisitions.

Write for your free copy of the Lilly Ampoule booklet. It contains a complete list of Lilly Ampoules with notes on parenteral medication.

ELI LILLY AND COMPANY

PRINCIPAL OFFICES AND LABORATORIES INDIANAPOLIS, INDIANA, U.S. A.

Vol. 51, No. 1, July 1938

No. 1

ovide y 500 hit in The rarily is are edical The n by treatil dewill

floor floor with third

large s for d on ighth oor."

ring conh the

ught the

tions e to

asso-

hosvices

nosis paid

nsur-

ation with-

ance ition

tosa, oresis the York

TAL

89

Council States Principles Relating to Hospital Care and Practice of Medicine

The board of trustees of the American Hospital Association adopted on June 18 a set of principles of relationship between medical practice and hospital care that was formulated by the coordinating council of the association on June 13. The principles are as follows:

1. The primary obligation of the hospital is to provide and organize all the services necessary for the diagnosis, treatment and rehabilitation of the patient.

2. Provision of medical services in hospitals is part of the responsibility of the hospital and is consistent with the rights, privileges and obligations of the hospital staff physicians under their medical licensure. The performance of diagnostic and therapeutic procedures by staff members constitutes the practice of medicine *in* hospitals. It is not the practice of medicine *by* hospitals.

3. The employment of a physician by a hospital is consistent with law and with professional ethics and does not imply that the hospital is engaged in the practice of medicine.

4. The financial arrangement between a hospital and a physician is not a determining factor in the ethics or legality of medical practice in hospitals.

5. No one basis of remuneration of a physician is applicable or suitable in all instances; nor should any such arrangement permit the hospital or the physician to exploit the other or the patient.

6. The medical work of physicians is coordinated through existing hospital staff relationships, resulting in higher quality of medical care, greater efficiency in hospital service and lower cost to the patient.

7. The responsibility for providing adequate and economical hospital care for the American people is not the responsibility of hospital trustees and administrators alone but calls also for the participation of hospital medical staffs and of the entire medical profession.

In commenting on the present situation, the statement points out that more than 10,000 physicians are now employed by hospitals on a full-time or part-time basis and adds:

"Demands have arisen in some quarters that hospitals be prohibited by law from providing services rendered or supervised by physicians. The association considers these demands contrary to sound existing practices in hospitals and to good medical standards, public welfare and public health. Present practices of hospital organization have been developed in response to public need and for many years fostered by the professional associations of this country, including the American College of Surgeons, the American Medical Association and the American Hospital Association.

"The discontinuance of the present relationships between hospitals and physicians would make it necessary for each patient to establish business relations with, and pay fees to, each physician contributing directly or indirectly to his care in the hospital. Such a multiple fee system would lower the quality of medical care, diminish hospital efficiency and increase costs of service to the hospital patient."

Hospitals Consider Relations With Plan for Hospital Care

More than 100 representatives of hospitals in the Chicago area participated in an all-day conference on June 7 to discuss their relationships with the Plan for Hospital Care. Matters of payments to hospitals, admission of plan patients and extension of the plan to include hospital employes were considered. Robert E. Neff, president of the American Hospital Association, addressed the group at noon, stressing the growing importance of hospital care insurance as it affects both the hospital and the layman.

An advisory board of seven hospital administrators was set up to consult with the board of trustees of the plan. Criticisms of any aspect of the plan or its administration were invited. It was announced that if the members of hospital medical staffs joined the plan they also could bring in their office employes as direct payment groups. This includes receptionists, nurses, technicians and any other persons employed by the physician.

Major in Administration

A nursing degree course with a major in hospital administration is being offered in the program for graduate nurses at the University of Pittsburgh. This program is available to graduate nurses who have completed a basic curriculum in a recognized nursing school. Three major courses are now being offered to graduate nurses: hospital administration, public health nursing and physiotherapy. Inquiries should be addressed to Dean Stanton C. Crawford, the College, University of Pittsburgh.

First Annual Meeting of New Hampshire Association Held in Manchester May 18

The first annual meeting of the New Hampshire Hospital Association was held at the Manchester Country Club, Manchester, May 18, with Mary L. Whittaker, president of the new association, presiding. The convention was held concurrently with the meeting of the New Hampshire Medical Society and was largely attended by trustees, physicians, guests and members.

Officers elected for the coming year are: president, Donald Smith, superintendent, Mary Hitchcock Hospital, Hanover; vice president, Louise Thompson, superintendent, Elliot Community Hospital, Keene; secretary, Ann McDougal, superintendent, Memorial Hospital, Nashua, and treasurer, Miss Whittaker.

In addition to state speakers, R. F. Cahalane, executive director of the Associated Hospital Service of Massachusetts, described hospital care insurance. At the present time the New Hampshire association is considering formulating plans for group hospital insurance.

City Closes Chicago Hospital

Charging conditions dangerous to the lives of patients and personnel, Dr. Herman N. Bundesen, president of the Chicago Board of Health, recently ordered the closing of the West Side Hospital, a 200 bed, 25 year old institution, almost opposite the site of the Cook County Hospital. Forty patients remained in the institution at the time the order was enforced by the police department. These patients were allowed to remain until they were dismissed or were able to be moved, but no more patients may be received.

bec

firs

of ·

fro

vai

col

tar

alc

ph

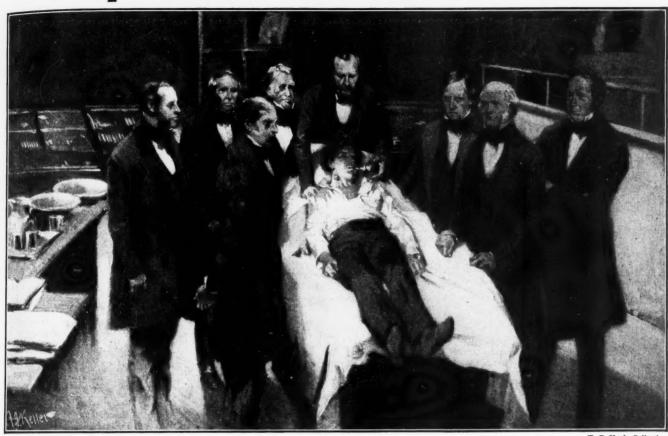
nit

su

The action brought counter charges from Dr. Charles C. O'Byrne, hospital administrator, who said that Doctor Bundesen's charges were false and "that other interests are attempting to gain control of the hospital because of petty technical defects."

Doctor Bundesen in an official statement had called attention to defective plumbing; to defective and contaminated drinking water and air conditions; to insanitary, even disease-carrying conditions among mothers and babies in the obstetrical operating rooms, delivery rooms and maternity wards. A bill of injunction to restrain the board of health's action was filed by the attorney representing the hospital.

Since the Days of Surgical Ether Hospitals Have Used Webb's Alcohol



T. F. Healy Collection

FIRST PUBLIC OPERATION UNDER ETHER-1846

Held at Massachusetts General Hospital, Boston, the demonstration of ether as a surgical anesthetic was a dramatic success. The patient was Gilbert Abbot, a 20-year-old printer. Dr. Morton was the anesthetist with Professor Warren operating for the removal of a tumor.

ALREADY an important aid to medicine, alcohol became a vital part of surgery when Dr. William T. G. Morton and Professor Warren performed the first public operation under ether.

Ether for that dramatic operation— and the tens of thousands that have followed since—was derived from alcohol. Although less useful materials have

vanished or have been replaced, alcohol has steadily grown in importance to hospitals.

Those who enter a hospital may not realize their dependence on alcohol. Yet it is everywhere—in the pharmacy, operating room, maternity ward, and laboratory. It has no substitute.

When hospitals use pure alcohol, they turn to Webb's and U. S. I.-U. S. P.—the leading brands. For as

far back as 1835, Webb's was their standard. Since James A. Webb & Son became a part of the U. S. Industrial Alcohol Co. in 1915, they place equal confidence in both products.

You, too, can have this confidence by specifying Webb's or U.S.I.-U.S.P.—the choice of more hospitals than any other single brand.



U.S. INDUSTRIAL ALCOHOL CO. 60 EAST 42ND STREET, NEW YORK

New was Club, ry L. asso-in was ng of ociety stees,

year perinpital, ompunity Mc-Hos-Miss

R. F. the assansur-New ering pital

the

Dr.

the

Side nstithe

ents

ime

olice

al-

dis-

but

rges

oital ctor

that

gain

etty

atetive

mi-

ndi-

rry-

and

ing

nity ain led

OS-

AL

Skits Brighten the Program at 3 Day Meeting of New York State Association

Skits on such subjects as social service, the pharmacy and labor brightened the program of the fourteenth annual convention of the Hospital Association of New York State held the last of May in Buffalo. These, as well as numerous papers presented during the three day meeting, attracted more than 400 hospital people from all over the state. As usual, the manufacturers staged a representative exhibit with some 53 companies taking advantage of the occasion to display their latest products for the hospital administrators and department heads.

Responsibility for the decrease of maternal and infant mortality must rest on the hospitals was the thought expressed by William B. Seltzer, superintendent, Bronx Hospital, New York, in discussing the achievement of a good obstetrical program in a modern hospital. Hospitals that provide good obstetrical facilities are the safest places for births, but many hospitals lack good facilities, he charged. Hospital administrators and department heads share with the medical profession the obligation to get the best obstetrical equipment and care for their institutions.

There is still a shortage of nurses, according to Dr. Frazer D. Mooney, president of the association and superintendent of Buffalo General Hospital. He declared in his annual report that there was criticism because of the number of graduates of Canadian schools given positions on nursing staffs but that the increase in the number of student nurses is solving this problem.

Dr. Frederick A. MacCurdy, chairman of the public relations committee, announced the formation of a committee to study labor relations for hospitals. Problems presented by union labor and labor laws must be carefully analyzed, be urged

The report of a study of a group prepayment plan for visiting nurse service in Westchester County was presented by Charles Neergaard, hospital consultant. This study reveals that such an arrangement made available to self-supporting families in the county is practicable and could be provided at a cost of \$1.40 a visit and that on a population basis the estimated average need is two visits per family annually. The proposed plan is to incorporate a nursing council for the county representative of the various agencies and to offer a group prepayment visiting nurse

service on a nonprofit basis which should be included among the benefits of the "3-cents-a-day hospital plan."

"If medicine will apply its collective intelligence to the problem of socialized medicine, instead of making blanket statements of opposition to something that exists in part already, there is less likelihood of crackpot legislation," said Roswell P. Rosengren, president of the U. S. Junior Chamber of Commerce, who spoke at the luncheon meeting.

"We must recognize that we have had socialized medicine in effect ever since any laws or ordinances have provided for free medical care in hospitals and for children in public schools," Mr. Rosengren declared.

One of the most constructive sessions of the entire convention was that devoted to plant problems. Speakers were carefully selected for their knowledge and experience in such matters as personnel, the power plant, hospital sterilization, painting, the laundry, floor maintenance and surgical lighting. Public relations as applied particularly to a hospital in a small community was another subject that was carefully considered.

Officers elected for the new year are: John H. Hayes, superintendent of Lenox Hill Hospital, New York, president; Jerome F. Peck, superintendent of Binghamton City Hospital, first vice president; Doctor MacCurdy, second vice president, and Austin J. Shoneke, superintendent of New Rochelle Hospital, treasurer. Carl P. Wright, superintendent of Syracuse General Hospital, continues as executive secretary.

Connecticut Trustees Hold Meeting

Hospital administrators and trustees gathered at the Meriden Hospital, Meriden, Conn., the latter part of May for a joint meeting sponsored by the Connecticut Hospital Association. Following the morning business session at which Joseph Hinsley, comptroller, Hartford Hospital, presented an outline of cost accounting, the day was devoted to trustee problems. A talk by Raymond P. Sloan, associate editor The MODERN HOSPITAL and trustee, Methodist Episcopal Hospital, Brooklyn, N. Y., abstracted elsewhere in this issue, served as a basis for discussion. Mrs. Lucy A. Pollock, super-intendent, W. W. Backus Hospital, Norwich, and president of the Connecticut Hospital Association, presided.

Montana Catholic Hospitals Hold Conference at Missoula

Fifty delegates, representing all the Catholic hospitals in Montana, attended the sixth annual Montana Conference of the Catholic Hospital Association held at St. Patrick Hospital, Missoula, May 18 and 19.

Officers reelected for a second term were: president, Sister Mary William, Miles City; first vice president, Mother Theosebie, Lewistown; second vice president, Sister Mary Ann, Anaconda; treasurer, Sister M. Wilhelmina, Great Falls; secretary, Sister Mary Magdalen, Missoula. Executive board members named were: Sister Mary Corona, Billings; Sister Mary Linus, Butte; Sister M. Visitation, Kalispell; Sister Germaine, Havre, and Sister Mary Ignatius, Fort Benton.

The guest speaker was the Rev. John W. Barrett, director of hospitals for the archdiocese of Chicago and second vice president of the A.H.A.

The Montana conference went on record as welcoming the evaluation and accreditation program of the Catholic Hospital Association.

Medical Social Workers Meet

An unusually interesting program on social service arranged by the North Atlantic District, American Association of Medical Social Workers, attracted a substantial audience to the New York headquarters of the American Red Cross.

Human welfare as a state enterprise was outlined by David C. Adie, commissioner, New York State Department of Social Welfare; Dr. H. Jackson Davis, chief medical officer, New York State Department of Social Welfare, discussed medical care as a basic component in a satisfactory public assistance program.

Also on the program was Linda J. Wharton, associate examiner for social work, New York State Department of Civil Service, who spoke on the civil service and its relation to social work standards.

Honor Doctor Overholser

A portrait of the late Dr. William A. White, formerly superintendent of St. Elizabeth's Hospital, Washington, D. C., probably will be presented to the hospital, it was announced at a dinner honoring the recently appointed superintendent of the hospital, Dr. Winfred Overholser, and Mrs. Overholser, given by the medical society of the hospital.



Saves FUEL! Resists FIRE! Deadens SOUND! IN ONE OPERATION—AT ONE COST!



SEE those large, rigid slabs of Thermax going into walls and ceiling? They'll save fuel, because Thermax has high insulating efficiency. They'll resist fire, because Thermax is made of clean, shredded fibres, coated and bound with fire-resistant cement. And, when plastered, they'll furnish sound insulation, reducing sound transmission from room to room or from floor to floor.

tals

all the ttended ference ociation issoula,

d term Villiam, Mother d vice conda:

Great gdalen, embers

Sister Ger-Igna-V. John for the

on and atholic

am on North ciation cted a York Red

enter-Adie,

epart-

ckson

York

elfare,

com-

assist-

da J.

social

ent of

civil

work

mA.

of St. gton, ed to

at a

inted

Dr.

Over-

ty of

ITAL

Thermax does all three of these important jobs well, yet it represents only one building operation and one

moderate material cost. Thermax is equally well suited for roof decks, ceilings, partitions, furring, and plaster base. And when left exposed, as on the under side of a roof deck, Thermax has marked sound-absorption value as well.

Widely used in fireproof construction, Thermax has the approval of building departments in leading cities of the United States and Europe, and is also classified by Underwriters' Laboratories, Inc. Mail the coupon today for complete information.



THERMAX REG. U. S. PAT. OFF.

STRUCTURAL INSULATING SLAB BY

CELOTEX

World's Largest Manufacturer of Structural Insulation

Washington Conference Will Consider Major Needs in Health and Medical Care

At the suggestion of President Roosevelt, a national conference on health and medical care has been called by the Interdepartmental Committee to Coordinate Health and Welfare Activities of the federal government. The conference will meet in Washington on July 18 to 20 and will be attended by about 100 nonofficial representatives of medical and health organizations, labor, agriculture and other groups.

Josephine Roche, former assistant secretary of the treasury, is chairman of the interdepartmental committee. The conference will have for discussion the report of the technical committee on medical care which was presented to the President last February. The section of the report dealing with hospitals appeared in the April issue of The MODERN HOSPITAL.

The technical committee consists of Dr. Martha Eliot, Children's Bureau, chairman; Dr. C. E. Waller, Dr. Joseph W. Mountin and George Perrott, all of the U. S. Public Health Service, and I. S. Falk, Social Security Board.

In an address prepared for the meeting of the American Medical Association in San Francisco last month, Miss Roche discussed the forthcoming conference and pointed out that it will have a substantial body of fact on which to work, drawn not only from the work of the technical committee on medical care but also from the national health survey conducted by the U.S. Public Health Service.

"The overwhelming central fact established by the national health survey," Miss Roche's paper stated, "is that with poverty goes not only a higher rate of sickness but a deficiency of medical care. These correlations were proved not only for the relief group but for struggling families above the level of relief. Never before had such a mountain of evidence been assembled to sustain the conclusion that among the poor there is an excess of sickness and death which requires preventive services and medical care proportionately greater than are required in the higher income groups."

The conference will be concerned not only with active demand but with actual need, it was intimated. "The problem of providing adequate health and medical services obviously demands concerted public action for its satisfactory solution," Miss Roche declared.

The technical committee will submit to the conference its analysis of needs and certain tentative recommendations as to means of meeting them. Its report deals with several broad problems, including the need for more comprehensive public health services to combat specific diseases; the need for expansion of maternal and child health services; the shortage or unequal geographic distribution of hospitals, clinics, doctors, dentists and other agencies and experts; the need of more adequate medical care for indigents and low income groups, and methods of financing the sickness costs of self-supporting persons.

It is not intended, Miss Roche declared, to take formal action on the report but rather to dissipate misunderstandings and "work toward a meeting of minds on the beginning of a coordinated national health program.'

New Orleans Press Praises Negro Hospital Achievement

The New Orleans Times-Picavune commented recently in its editorial columns on the annual report of the superintendent of Flint-Goodridge Hospital of Dillard University, a local institution for Negroes, and commended its noteworthy achievements.

Chief among these has been its systematic improvement of maternity conditions for the Negro population. The percentage of Negro babies born in the hospital during 1935 was larger locally than the percentage of white babies. Even more remarkable, the Times-Picayune points out, the percentage of Negro babies delivered by midwives for that year was smaller in New Orleans than the number of white infants so delivered.

This has been achieved partly through educational work conducted by staff workers among Negro mothers and partly by reducing the hospital fee in such cases. The Flint-Goodridge Hospital insurance plan was one of the first to receive the approval of the American Hospital Association.

Woman's Hospital Reports

The Woman's Hospital, New York, reports that during 1937 the institution cared for 16,088 individuals and gave a total of 74,207 days' care in the wards and private rooms. Births totaled 1516 and there were no maternal deaths among the 942 obstetric cases cared for in the wards.

New York Vocational Service Merges With Chicago Bureau

On July 1 the public health nursing division of the Joint Vocational Service, New York, was transferred to the Nurse Placement Service, 8 South Michigan Avenue, Chicago.

With this merger the National Organization for Public Health Nursing assumes sponsorship for part of the placement work of an organization established by the midwestern division of the American Nurses' Association in 1931.

Elizabeth J. Mackenzie, R.N., associate director, Henry Street Settlement Visiting Nurse Service, New York, has been appointed as assistant in the development of public health nursing vocational work as a member of the staff of the Nurse Placement Service. Anna L. Tittman, R.N., is executive director of the Nurse Placement Service.

Tennessee Hospitals Organize

Representatives of Tennessee hospitals met May 18 at Vanderbilt University Hospital, Nashville, under the chairmanship of its superintendent, Clarence P. Connell, to organize the Tennessee Hospital Association. V. Robert Bottomley, R.N., superintendent of Takoma Hospital and Sanitarium, Greenville, was elected president.

Coming Meetings

- Canadian Nurses Association. Next meeting, Halifax, N. S., July 4-9.
- National Health Conference. Washington, D. C., July 18-20.
- National Hospital Association. Next meeting, Hampton, Va., Aug. 14-16.
- American Congress of Physical Therapy and American Occupational Therapy Association. Joint sessions, Palmer House, Chicago, Sept. 12-15.
- American Hospital Association.
 Annual convention, Dallas, Tex., Sept.
- American Protestant Hospital Association. Next meeting, Dallas, Tex., Sept. 30-Oct. 2.
- American Dietetic Association. Next meeting, Milwaukee, Oct. 9-14.
- Next meeting, Milwaukee, Oct. 9-14.

 Missouri State Nurses' Association.

 Next meeting, Kirksville, Oct. 17-19.

 Association of Record Librarians of North America.

 Tenth Annual Conference, New York, Oct. 17-21.

- Oct. 17-21.

 American College of Surgeons.

 Next meeting, New York, Oct. 17-21.

 Ontario Hospital Association.

 Next meeting, Toronto, Oct. 19-21.

 American Public Health Association.

 67th Annual Meeting, Kansas City,

 Mo., Oct. 25-28.
- Kansas Hospital Association. Next meeting, Pratt, Oct. 29.
- Next meeting, Fratt, Oct. 25.

 Symposium on Mental Health of American Association for the Advancement of Science.

 Next meeting, Richmond, Va., Dec. 28-30.

AND CHAIN

In these uncertain times, one thing IS certain... every item in the Will Ross catalog is GUARANTEED UNCONDITIONALLY » »

WILL ROSS, Inc.

Wholesale Distributors and Manufacturers of Hospital Supplies

3100 W. CENTER ST.

MILWAUKEE, WIS.



M. BURNEICE LARSON, DIRECTOR

.. we think we'd find it for you

If you would write and tell us of the work you'd like to find, tell us of the kind you'd *love* if ever you could find it . . . we think we'd find it for you.

We would ask you first to tell us all there is to tell about yourself; would want to find that you are fine and smart, an eager sort of person, curious about the ways of people who are ill, curious and anxious to learn the newer ways of medicine and surgery, no matter how much you know today. We'd like to know that you are cheery, hard to down; would like to know that you've the will and strength to do the things that must be done; would like to know that you are honest, fair in mind, fairly unselfish, kind.

Knowing these things, and things like these of you, we would find the niche that needed you fit you into it happily; give you opportunity to do the things you love to do, opportunity to loose the enthusiasm, trained mind, intent and will that have been pent in you for years

..... if you would write and tell us of the work you'd like to find, tell us of the kind you'd love if ever you could find it we think we'd find it for you. That is our great work.

The MEDICAL BUREAU

55 E. Washington Street CHICAGO, ILLINOIS

ice ureau ursing Service, to the South al Orursing of the zation ivision ciation , assok. has develvocae staff Anna irector

ze

hospiniverr the ndent,

the V.

rium,

4-9.

lug.

ago,

ept.

9.

ork,

-21.

ity,

ITAL

Names in the News

Administrators

Lois A. Roscoe, R.N., for the last ten years superintendent of Olean General Hospital, Olean, N. Y., has been appointed superintendent of Fort Hamilton Hospital, Hamilton, Ohio. She will be succeeded at the Olean hospital by Liala I. Johanson, R.N., of Detroit.

Dr. Benjamin W. Black has declined an offer to become warden of Cook County Hospital, Chicago, at a salary of \$18,000 a year. He stated that he would not contemplate leaving his post as health director of Alameda County, California, for the "insecurity that goes with pioneering in a new job."

J. F. Morrison, assistant superintendent of the Hendrick Memorial Hospital, Abilene, Tex., and president of the Northwest Texas Clinic and Hospital Managers Association, has been chosen superintendent of the new Clovis Municipal Hospital now under construction at Clovis, N. M. Mr. Morrison has had twelve years of experience in hospital management. Both he and Mrs. Morrison are registered nurses.

DR. WILLIAM W. BACHMAN, superintendent of Pleasant Valley Sanatorium, Bath, N. Y., for two years, has resigned. DR. ELWOOD STEVENS, Hammondsport, N. Y., has been designated acting head until a successor to Doctor Bachman is selected.

Jane Rainey, after four months as superintendent of the Angelina County Hospital, Lufkin, Tex., has announced her resignation to accept the superintendency of a new county hospital at Conroe, Tex. Miss Rainey objected to the large amount of charity work being cared for at the hospital, which was not being supported by county funds. She formerly was admitting officer for the John Sealy Hospital, Galveston, Tex.

DR. RALPH ROSSEN of St. Peter, Minn., has been named superintendent of the Hastings State Hospital, Hastings, Minn., to succeed WILLIAM J. YANZ, who is retiring.

DR. D. L. SPRINKLE of Baltimore has been appointed superintendent and director of the x-ray department at Tampa Municipal Hospital, Tampa, Fla. He succeeds T. F. ALEXANDER, who resigned recently. Under the present setup of the hospital, two leading x-ray specialists of Tampa do the work for the hospital with its equipment. The appointment of Doctor Sprinkle in a dual capacity will end their asso-

ciation with the hospital in that connection. Doctor Sprinkle has completed two years of service as associate roentgenologist and resident director at the University of Maryland Hospital.

ELMINA WASMER, for the last twelve years superintendent, Eastern Long Island Hospital, Greenport, Long Island, N. Y., has resigned. The post of administrator is being taken temporarily by ANNE NITSKY, a member of the hospital's nursing staff.

A. L. MORLAND, who since 1912 has been head accountant and for a number of years treasurer of Emanuel Hospital, Portland, Ore., has been appointed superintendent of the institution, succeeding the late Rev. Axel M. Green.

ELLA MOFFAT, superintendent of Galt Hospital, Galt, Ont., has resigned after serving as superintendent for more than two years.

Department Heads

ALICE P. MAULL, director of nursing at Barnes Hospital, St. Louis, for the last six years, has accepted the position as director of nursing at Ravenswood Hospital, Chicago, beginning September 1. She will succeed ADA KOEBKE, who resigned to accept the position of director of nursing at West Suburban Hospital, Oak Park, Ill.

THELMA DRIVER, formerly of the medical records department of Lakeside Hospital, Cleveland, has accepted the position of record librarian at City Hospital, Akron, Ohio.

DR. EUGENE N. NESBITT, medical director of Sunshine Sanatorium, Grand Rapids, Mich., has resigned because of illness.

LUCILE E. MITCHELL, a graduate of R. F. Strickland and Son Memorial Hospital, Griffin, Ga., has been appointed superintendent of nurses at Calvin and Ritch Sanitarium, Jesup, Ga.

DR. CHARLES E. MARTIN, medical director of Albany Hospital, Albany, N. Y., recently was elected president of the Northeastern New York Hospital Association.

MARGARET McCormick has been promoted from her post as surgical nurse to superintendent of nurses at Holden Hospital, Holden, W. Va., to succeed the late Mary Gaule.

DR. LESTER C. HUESTED, a member of the surgical staff at New York Hospital and instructor in surgery at Cornell University Medical College, has been appointed resident surgeon at Grasslands Hospital, Valhalla, N. Y.

MARY L. CROUCH, director of nurses at Henrotin Hospital, Chicago, since 1936, has been selected to succeed E. LOUISE GRANT, resigned, as director of nurses at Allentown Hospital, Allentown, Pa.

Miscellaneous

SISTER JOHN GABRIEL, hospital consultant and educational director, Sisters of Charity of Providence in the Northwest, has resigned from her position because of ill health. She is now taking a long rest.

DR. WILLIAM H. WALSH of Chicago, consulting specialist on hospitals, will conduct the Chicago Medical Society's survey of the need and supply of medical care in Cook County, which is part of the national survey being conducted by the bureau of medical economics of the American Medical Association. Doctor Walsh will be assisted in this study by Dr. NEAL N. WOOD, formerly superintendent of the Los Angeles County Hospital, and more recently of the Starling-Loving University Hospital, Columbus, Ohio. The cost of the survey probably will be around \$25,000, which is to be defrayed by the Chicago Medical Society.

ALDEN B. MILLS, managing editor, The Modern Hospital, has been invited by Josephine Roche, chairman of the President's Interdepartmental Committee to Coordinate Health and Welfare Activities, to participate in the National Health Conference in Washington, D. C., July 18 to 20, as the spokesman for rural hospitals.

LOUIS C. RITTMEYER has been appointed business manager of the Hamilton County Tuberculosis Sanatorium, Cincinnati. The new post is exempt from civil service.

MARGARET L. PLUMLEY, known in the hospital field for her studies of out-patient work and her recent participation in the hospital surveys of the U. S. Public Health Service, has accepted a position on the staff of the Committee on Research in Medical Economics, New York, of which MICHAEL M. DAVIS is chairman.

Deaths

MACOMB G. FOSTER, for many years identified with the Knickerbocker Hospital, New York, died unexpectedly at the age of 78 years. Mr. Foster became president of the hospital in 1910 following a service of twenty-three years as trustee. He served as president until 1925 and as trustee until 1936.

Dr. Walter J. Britt, 61, head of the Britt Infirmary, Eufaula, Ala., which he established, died recently. nurses since cceed rector Allen-

con-Sisters Northsition aking icago,

, will ciety's medis part ucted ics of Docstudy superounty f the spital, sur-5,000,

icago ditor, n inan of Com-Welthe Vashs the

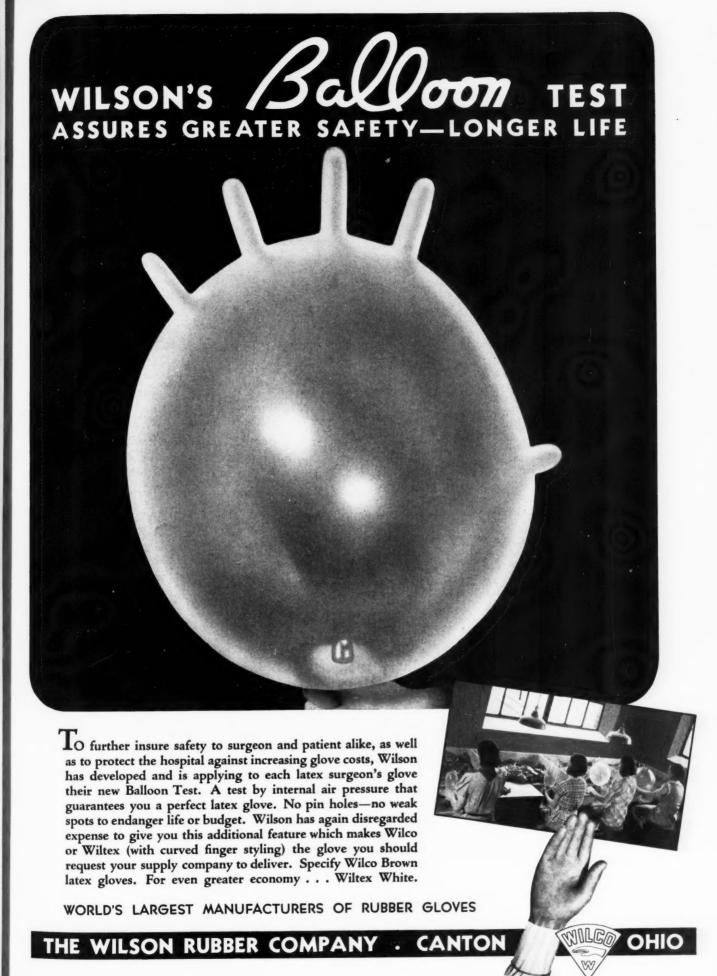
ap-Hamrium, empt n in es of

parof the s ac-f the edical vhich

vears Hostedly oster al in entyd as ustee

d of Ala., ly.





New Jersey Association Focuses Its Attention Upon Hospital Trustees

A change from the seashore where its annual meeting is usually held brought members of the New Jersey Hospital Association to Jersey City for its fourteenth convention, June 2 to 4. In the new auditorium of the medical center, administrators and department heads from all over the state met to consider mutual problems and also to take advantage of this opportunity to study at first hand the tremendous institution which even today is in process of expansion.

The presence of Frank Hague, mayor of Jersey City, attracted an audience that filled the auditorium to overflowing. Much interest was evidenced in his description of the new building for which ground recently has been broken. A complete hospital and school home for children deprived of care when their parents are hospitalized is the latest adjunct to the medical group.

Much attention was given during the various sessions to the part which the trustee is destined to play in meeting present day hospital problems. A special trustee section, with William Orchard, trustee, Orange Memorial Hospital, Orange, serving as chairman, brought nearer to realization the organization of hospital trustees throughout the state.

"A group of us," said Mr. Orchard, "have been pondering for many months the best methods for organizing the power of our trustees. After much thought it has seemed wisest not to start a new movement but to supplement the one already in existence by providing, as a component part of the New Jersey Hospital Association, a trustees' section that would enlist the support of our membership."

Of vital interest to trustees as well were Howard S. Cullman's remarks on how hospitals can make up for the inadequacy of community chests and donations. Mr. Cullman is president of Beekman Street Hospital, New York City. Increased help from government funds and broadened plans of hospital care insurance are the principal means through which voluntary hospitals can be placed on a sound financial basis, he stated.

Subsequently, Raymond P. Sloan, associate editor of The Modern Hospital and trustee, Methodist Episcopal Hospital, Brooklyn, N. Y., discussed the function of hospital trustees as applied particularly to the public relations program.

Dr. E. M. Bluestone, director, Montefiore Hospital, New York, outlined hospital concepts of tomorrow, emphasizing particularly the need for adequate provision for chronic disease care.

Officers of the association for the new year are: president, Dr. Edward Guion, superintendent, Atlantic County Hospital, Northfield; president elect, Mary Stone Conklin, superintendent, Hackensack Hospital, Hackensack; vice president, F. Stanley Howe, superintendent, Orange Memorial Hospital; treasurer, Thomas J. Golden, Medical Center, Jersey City. Fred W. Heffinger, superintendent, Mercer Hospital, Trenton, who has been serving as executive secretary, becomes recording secretary. The post of executive secretary will be filled later.

Greater New York Group Meets

Assurance that adequate hospital facilities will be available to all those attending the New York World's Fair in 1939 was given by Dr. S. S. Goldwater, New York commissioner of hospitals, in a talk before the annual meeting and luncheon of the Greater New York Hospital Association held at the Hotel Commodore. Doctor Goldwater urged a closer coordination between public health and city hospital services. Other speakers introduced by Dr. Willis G. Nealley, president of the association, were: Dr. John L. Rice, department of health; David H. McAlpin Pyle, United Hospital Fund, and John H. Hayes, newly elected president of the Hospital Association of New York and superintendent of Lenox Hill Hospital. Officers of the association for the new year are: president, Dr. C. W. Munger; first vice president, Rev. Joseph Brophy; second vice president, John McCormack; treasurer, George F. Holmes; secretary, William B. Seltzer.

Doctors Attack Hospitals

(Continued from page 88)

state in the Union, many hundreds of cities and counties, state and private universities, ecclesiastical hospitals of many denominations and nonsectarian community hospitals are engaged in the practice of medicine.

"It is inconceivable that an intelligent medical profession will refuse to cooperate with hospitals that are eager to serve the public and propose to do so in a manner which rigidly excludes profiteering and which is not only acceptable, but responsive to the needs of their staff members."

Doctor Jackson Will Abandon Surgery for Safety Lectures

Dr. Chevalier Jackson, famous Philadelphia bronchoscopist who, during a half century of practice, has saved the lives of thousands of children strangled by swallowing foreign objects, has announced he has decided to abandon that career.

The famous surgeon, who will be 73 years old in November, believes he can prevent more deaths by going about the country lecturing to welfare groups and mothers' clubs on carefulness than by performing operations.

"Most parents and nurses simply do not realize that children are imitative," Doctor Jackson was reported as saying by the New York Times, "and this they must learn if we are to reduce the number of these cases. In dressing or undressing a youngster, a mother will unclasp a pin and put it in her mouth. The child, seeing this, later puts the pin in its own mouth, perhaps when dressing its doll."

READER OPINION

We Want Only to Live

Sire

I am sure you will understand that I have to try everything and that you will therefore forgive me this letter.

All what I have to say is that I am a young Austrian physician with two years' experience in the well-known Viennese hospital "Poliklinik." I also am well trained in histology, bacteriology, serology and in all chemical laboratory works; besides this I have knowledge of massage, hydrotherapeutics and electrotherapeutics. I was dismissed from the hospital in consequence of the events in Austria and so I am denuded of all possibility to earn my living here.

For this reason I am forced to leave my country but as you will know nearly all the countries in Europe and abroad are strictly closed to us. For weeks and weeks I have tried everything to get a chance, without geting the slightest hope. I learned from friends here that the U.S.A. has much sympathy for us and I was informed by the Viennese consulate of the U.S.A. that a considerable number of Austrians will be able to get the permit of entering the States during the next months. Unfortunately, I have neither relations nor friends in America and therefore I can't find a chance to get the necessary permit.

chance to get the necessary permit.

Such an affidavit would mean, as you will understand, a real first prize to me. I am not so optimistic but as I am young and willing to do every work I am sure I will find some job for a modest living. Perhaps you have knowledge of people who would be human enough to procure an affidavit for me and my wife. I take the liberty of informing you that I am just married and that my wife is also willing to do every kind of work.

I can assure most emphatically that we have not the slightest intention to be anyone's burden in America; we only want to live and to work there.

Dr. Georg Salz. Taborstrasse 54, Vienna, 11, Austria.

Vol

HAWTHORNE Model

ndon ctures us Phil-

luring a

ved the rangled

has anbandon

will be

eves he

careful-

nply do itative,"

saying

nd this

reduce

dressing

mother in her s, later perhaps

t I have therefore

a young perience "Poliistology, ical lab-

owledge rothera-

spital in and so I arn my

ave my

all the strictly

I have out getfriends

y for us onsulate

nber of rmit of

months. ons nor

t find a ou will

am not

willing

d some

u have

human and my ou that is also

ve have e's burand to

SALZ.

PITAL

ions.

going welfare

Ask for Specification No. SS-3044.

NURSES' CHART DESKS

MADE COMPLETELY OF STAINLESS STEEL AT ONLY A SLIGHT DIFFERENCE IN COST **OVER ENAMELED DESKS**

We list but a few of the manifold advantages of these Nurses' Chart Desks, made completely—not just in part—of this attractive and durable modern alloy.

- 1. Absolute sanitation-can be washed without injury or completely sterilized.
- 2. Entirely rust-proof and non-tarnishing.
- 3. Cannot chip, crack, or wear, as Stainless Steel is a solid metal-not a coating.
- 4. One-piece, all-welded sanitary construction, in order to avoid joints, crevices or vermin-inviting seams.
- 5. Extremely attractive appearance, as the Stainless Steel surfaces are artistically polished in a twotone effect.
- 6. Will last indefinitely-no replacement, repair, or repainting costs.

We also manufacture a complete line of Nurses' Desks in Enameled Steel as well as Chart Racks, Chart Holders and Chairs. Write for our illustrated Bulletin 2 C D as well as other bulletins describing our complete line of Modern Hospital Equipment.

MANUFACTURERS OF HOSPITAL EQUIPMEN

with Clock-like Precision

SCIENTIFICALLY CORRECT

That's how HEIDBRINK APPARATUS for Gas Anesthesia is built . . . and that's why so many anesthetists prefer it. The HEIDBRINK KINET-O-METER with its accurate, trouble-free DRY FLOAT Flow Meters enables the anesthetist to proceed with an ease and certainty that instills confidence . . . so necessary in surgery. There's no freezing, no filling and no sediment to contend with. Available in Cabinet, Stand or Cart Models . . . each combining all the features of recognized excellence and economical operation that have made HEIDBRINK apparatus truly outstanding.



you'll know why so many hospi-tals are discarding their present equipment and installing HEID-BRINK APPARATUS for Gas Anes-

HEIDBRINK DIVISION

MINNEAPOLIS . MINNESOTA

Vol. 51, No. 1, July 1938

LITERATURE in ABSTRACT

Conducted by E. M. Bluestone, M.D., and Joe R. Clemmons, M.D.

Resuscitation in Asphyxia

Corvllos* analyzes the various causes of asphyxia and groups them as follows: (1) insufficient oxygen in the inspired air; (2) obstruction of air passages; (3) obstruction to the passage of gases in the alveoli; (4) diminution in the oxygen carrying capacity of the blood; (5) circulatory failure; (6) mixing of venous with arterial blood, and (7) inhibition of oxydative processes in the tissues. Of these the second, third and sixth are of importance to the thoracic surgeon.

The author divides asphyxia into four phases. The first phase is characterized by apnea and rise of blood pressure. This phase lasts about one minute. The second phase is characterized by labored respiration and continuance of the rise in blood pressure. This also lasts about one minute and then consciousness disappears and convulsions appear. The third phase is characterized by stoppage of respiration, drop of blood pressure and disappearance of reflexes. This also lasts one minute. The fourth phase is characterized by progressing weakness of cardiac contraction and arrest of the

Prognosis is different in each of these phases. When the cause of the asphyxia is removed before the middle of the third phase, immediate and spontaneous resuscitation follows. Towards the end of the third phase spontaneous resuscitation becomes more difficult. These studies in asphyxia were made upon dogs. The asphyxia was caused by submersion or by bronchial obstruction and by respiration of anesthetic gases.

Coryllos feels that a great percentage of the mortality in thoracic surgery is due to the fact that the patients have been suffering from a chronic anoxemia resulting from uneven pulmonary ventilation, edema of the respiratory membrane, partial destruction of the pulmonary parenchyma or atelectasis of the lung. The slightest increase of anoxemia in any of these patients may cause sudden death.

Apparently, the best means of combating asphyxia has been "mouth to mouth" insufflation. Unfortunately this cannot be maintained for long periods of time and it will not work when the airways are obstructed. Furthermore, there is danger to the operator in cases of tuberculosis or suppuration of the

The author sought a mechanical device that would take the place of 'mouth to mouth" insufflation and decided to investigate the E. & J. Resuscitator. After exhaustive experimental investigation he came to the conclusion that: (1) the apparatus was technically reliable and constant in its action; (2) its prolonged use was without any danger to the patient; (3) it was efficacious in the various types of asphyxia; (4) it could be used during long operations upon the intrathoracic organs (experimental), and (5) it was a definite aid in the resuscitation of patients who had developed apnea in the course of or following thoracic operations.

Coryllos concludes that although manual artificial respiration with oxygen carbon-dioxide inhalation is an efficient procedure for the early stages of asphyxia it becomes useless in the later stages. When apnea has developed, only forcible insufflation methods will produce resuscitation. The automatic respirators such as the Drinker and Emerson are the only ones suitable for cases of paralysis of the respiratory

The conclusion was reached that, as a rule, mechanical insufflation and suction need be applied for a relatively short time and only until spontaneous respiration occurs. Following spontaneous respiration only the inhalation method is needed. The ideal mechanical apparatus for resuscitation is therefore a machine that combines an inhalator and a resuscitator. The E. & J. apparatus fills this need. It is relatively foolproof and may be used by nonmedical but trained rescue squads.

*Coryllos, Pol N., M.D.: Mechanical Resuscitation in Advanced Forms of Asphyxia, S. G. & O. 66:698, 1938. Abstracted by Arthur H. Aufses, M.D.

Tensile Strength Control

Control of the stain removal operation is synonymous with control of tensile strength losses.* The bleach reacts with the oxidized fabric cellulose to form oxycellulose, which does not have the structural strength of the original cellulose fiber. Excessive amounts of bleach further reduce the strength of the fabric. The weight of the clothes can be estimated to within 25 lbs. for larger loads, less for smaller, and is sufficiently close to effect good control if the strength of bleach is known and the quantity measured.

The equipment required to test the chlorine strength of the bleach solution is: a support, a burette clamp, a 10 or 25 cc. burette, a 150 cc. beaker, stirring rod, 1 cc. pipette, 5 cc. pipette, potassium iodide crystals, one-tenth normal standardized solution of glacial acetic acid, sodium thiosulphate solution. Place the burette in the clamp attached to the support, rinse and fill it to the top with sodium thiosulphate. Add about 50 cc. of cold water to the beaker and exactly 1 cc. of the bleach sample. Stir. Pour the sodium thiosulphate from burette to beaker and stir until the solution turns colorless. To determine number of cubic centimeters of sodium thiosulphate used, multiply by Result: available chlorine 0.355. strength of the sample tested.

The amount of bleaching solution per 100 pounds of clothes is variable and may require from 1 quart to 4 quarts of solution. Stain removal may be obtained at a temperature of 140° to 150° F. If hot water temperatures are insufficient to give 150° F. on the bleaching operation, heat the wheel to 150° F. with live steam, preceding the

bleach operation.

If water of 150° F. cannot be furnished, steam should be run in to the wheel until the proper bleaching temperature is reached, the steam shut off and the bleach added. Steam in the wheel while the bleaching solution is there will cause the quick liberation of the chlorine and increase the destructiveness of the bleach while decreasing the stain removal value.

*Deegan, Philip J.: The Control of Tensile Strength Losses, Recent Trends in Washroom Procedure, Laundry Short Course, Texas A. & M. College, 1937. Abstracted by Barbara Allen.

Bleach Bath for Stains

The functions of the bleach bath are to effect stain removal with the minimum amount of bleaching of fabric in order to sterilize the clothes and to remove any inorganic soil.* The oxidizing bleach is applied after the clothes have been thoroughly cleaned by the soap solution since the temperature of the early bath is too low for stain removal and soil has a destroying effect on the bath.

A high pH. in the bleach bath, obtained by the use of alkali with the bleach, slows up oxidation thereby increasing the effect of the stain remover.

Commercially prepared concentrated sodium hypochlorite, ready for use after dilution with water, will remain stable for a long period of time.

^{*}Deegan, Philip J.: Bleaching-the Second Step in the Washing Cycle, Recent Trends in Washroom Procedure, Laundry Short Course, Texas A. & M. College (1937). Abstracted by Barbara Allen.

STRIKING IMPROVEMENTS in Metal Furniture!

We have perfected, during the past few months, many outstanding improvements in practically every branch of our line. Not superficial touches . . . but basic changes, all of marked value to you.

You will find these improvements already incorporated in our entire line ranging from the artistically styled modern chromium furniture for reception rooms and solariums . . . to the rugged heavy duty equipment for mental hos-

Tell us which line is of interest to you and we will gladly send complete details.

Doehler publishes the only catalog covering all types of furniture used in the hospital field. Would you like a copy? It's your's for the asking.



est the olution

10 or tirring potas.

normal

acetic

lution.

tached

to the

Add beaker

ample.

lphate

until

deter-

ers of ply by

lorine

lution

riable

to 4

l may

1400

atures

n the

eel to g the

e fur-

o the

tem-

ut off

n the

on is on of struc-

asing

Tensile

hroom A. & Allen.

n are

mini-

ic in

d to

OXI-

the

aned

tem-

low

de-

obthe

v in-

over.

ated use

nain

cond ds in

ourse,

d by

TAL

DOEHLER

METAL FURNITURE CO.

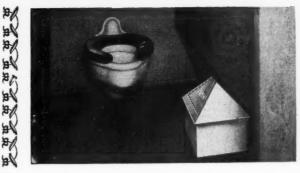
INCORPORATED

Main Offices and Showroo 192 Lexington Ave. at 32nd St., New York, N. Y.

Cleveland, Ohio

Branch Offices
Boston, Mass.
Washington, D. C.

Montpelier, N. H.



OLAR Receptacles

Essential For WOMEN'S TOILETS in Hospitals and Nurses' Homes



Easy to Use



Easy to Empty

Solar Receptacles are easily used, silent, individual, and ever closed. They permit easy disposition and privacy. The paper bag containers make later removal equally simple. They are fireproof, odorproof, verminproof. Stoppage of flush pipes is reduced. Plumbing bills are cut. A constant inducement to keep surroundings clean. Write today for full information on these modern (all-steel), self-closing waste receptacles. No obligation.

Corridors

Laboratories

Wards

Examining Rooms

Clinics

Washrooms

or Wherever

Waste

Accumulates

SOLAR-STURGES MFG. CO. MELROSE PARK, ILLINOIS



SAY HOSPITAL SUPERINTENDENTS

So simple and easy to operate is the "SPHINX" Lincoln SingleDisc machine that any inexperienced attendant can swiftly scrub,
wax and polish floors to perfect sanitary cleanliness. So economical
that it pays for itself out of savings in time, labor, and materials.
So SILENT and efficient in operation that it is the overwhelming selection of leading Hospitals all over the
country. Competitive tests show that the Lincoln SingleDisc turns out a better job more silently and in less
time. You'll agree with every claim and become an
enthusiastic user if you take advantage of this . . .

FREE TRIAL OFFER

Let us send you one of these out-

MAIL COUPON TODAY

Let us send you one of these outstanding machines for 5-DAY FREE TRIAL. You'll be fascinated as you watch it QUIETLY glide across your floors, leaving a clean sanitary surface. Equipped with Automatic control switch that snaps "OFF" when operator's hands are removed.

	Ĩ
738	1
	- 1

LINCOLN-SCHLUETER FLOOR MACHINERY CO. 738
247 W. Grand Ave., Chicago, Ill.
Please send me full details of your 5-Day FREE TRIAL OFFER, also complete specifications on the new Lincoln Single-Disc machine. NAME.

ADDRESS

STATE

RFECT SERVICE Hall China has wholesome beauty that appeals to lagging appetites, dense heat-retaining walls that assure hot service of food and beverages, a sturdy body that means long life, and crazeproof glaze that guarantees easy cleaning and complete sterilization. This combination of qualities meets every hospital requirement for perfect service. HALL FIREPROOF CHINA HALL CHINA COMPANY - ERST LIVERPOOL, OHIO



MONARCH
"Finer Foods"



are safe foods

Monarch Finer Foods are SAFE foods—selected from the finest grown, and packed with the utmost regard for purity and sanitation. Scores of America's leading hospitals prefer Monarch Finer Foods because they know they are SAFE foods which they can serve not only with real economy, but also real security.

Write, wire or phone (SUPerior 5000) for representative to call—today.

Institution Department

REID, MURDOCH & CO.

CANNERS AND MANUFACTURERS
Department MH-7 Chicago, Ill.



Fruits Without Sugar Also a fine and varied selection of solid pack pie fruits under our Red Lily Label.

selection is found in the selection is fruits our Red "Quality for 85 years"

A selection of Dietetic fruits and vegetables is also provided under the Monarch Label.

BOOKS ON REVIEW

MANUAL OF PSYCHIATRY AND MENTAL HY. GIENE. Seventh Edition. By Aaron J. Rosanoff. New York: John Wiley & Sons, Inc., 1938. Pp. 1091. \$750.

This is the seventh edition, rewritten and enlarged, of Rosanoff's popular "Manual of Psychiatry and Mental Hygiene."

The first part deals with etiology, symptomatology, neuropsychiatric syndromes and general pathology. The second part deals with special neuropsychiatric syndromes based as far as possible on etiology. The third part deals with the practice of psychiatry and investigation methods. The fourth is concerned with mental hygiene, eugenics, prevention of disease, the alcohol problem and childhood difficulties. Part 5 gives the details of special methods of examination, and Part 6 is an appendix containing miscellaneous information, official classification of mental disorders, height and weight norms and intelligence quotients.

The book is full of information, and while the author claims to give a general view of the material without any special bias, happily the latter stipulation is not entirely fulfilled so that the book carries a special flavor and a delightful one in many instances. For example, in his treatment of ethical problems as part of the body of scientific knowledge the author is certainly on good ground, even if his position is contested these days by more narrow-minded scientists.

One comes upon some peculiar things in the text which result from the author's effort to reduce things to an etiologic classification. For example, the discarding of a separate chapter on schizophrenic psychoses and reference to this material being scattered about in a number of places, being concentrated somewhat under the title of "chaotic sexuality," leaves the reviewer somewhat ill at ease.

The volume contains a disproportionate amount of material concerning organic brain disease. Likewise, there is too much attention paid to the theoretic data of heredity.

In spite of these points of difference with the reviewer's outlook, the book has much authoritative and excellently presented information and can be heartily recommended to students and workers in the field.—Wendell Muncie, M.D.

J. B. MURPHY, STORMY PETREL OF SURGERY. By Loyal Davis, M.D., Chairman of the Division of Surgery, Northwestern University. New York: G. P. Putnam's Sons, 1938. Pp. 311. \$3.

A button and two buildings bear the name of J. B. Murphy, and that is about all that the newer generation knows of a brilliant man of medicine who had an almost equal genius for surgery and for trouble.

This lack can now be remedied for Dr. Loyal Davis, a successor of "J. B.'s" in the chair of surgery at Northwestern, supplies these persons, lay and medical, with the colorful facts of this tempestuous career. If a medical man walks the streets today more vibrant with life than Doctor Davis' Murphy, he has not crossed our meandering path.

From the days of Chicago's historic Haymarket Riot until his death at the beginning of the World War, this energetic, shrewd and daring surgeon made enemies and friends, fame and fortune, and medical history.

Doctor Davis in an honest and skillful biographer.—M. W.

AN EASIER WAY to keep Lavatory Fixtures.

TAL HY.

91. \$7.50. darged, of d Mental

pmatology, gy. The syndromes part deals methods. eugenics, childhood ethods of ning misental disquotients. he author thout any tentirely

or and a e, in his of scienground, e narrow-

xt which
is to an
ing of a
reference

of places,

"chaotic

there is

heredity. eviewer's

cellently

ended to E, M.D.

y Loyal

Surgery,

utnam's

B. Mur-

knows

t equal

Davis, a

North-

ith the

al man

Doctor path. ot until

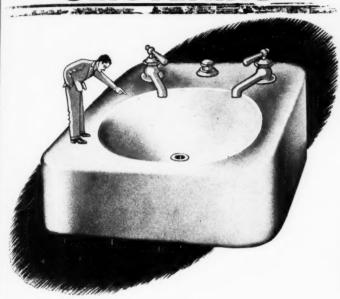
ergetic, friends,

M. W.

PITAL

ease. of mate-

GLISTENING



Hundreds of hospitals have made an important discovery . . . when wash basins, tubs and toilets are cleaned the Oakite way.

Every trace of dirt, stains and rings are removed, of course. But equally important is the way porcelain surfaces glisten with sparkling cleanliness. This is due to the fact that there is not a grain of abrasive in the Oakite solution. It does its job and then rinses away freely, completely. Its emulsifying effect helps keep drains open . . . preventing pipe accumulations and their attendant odors.

Oakite cleaning is safe. It cannot scratch or mar. Economical, too. Write for complete information.

Manufactured only by
OAKITE PRODUCTS, INC., 18A Thames St., New York, N.Y.
Branch Offices and Representatives in All Principal Cities of the U.S.

OAKITE Lertified CLEANING

MATERIALS & METHODS FOR EVERY CLEANING REQUIREMENT

Metal · Glass

CLOTHES CHUTES

for South America



Metal-Glass chutes are used all over the world. Here are three plant views of a shipment going to South America. No other chute is so dependable—so durable—so friction-free and snag-proof for textiles. Send for complete literature and a list of installations near you where you may see and inspect a Metal-Glass chute for yourself.

PORCELAIN PRODUCTS CO. 1427 South 55th Court · Cicero, Illinois

SPEEDS UP

BATHING ROUTINE



Your nurses spend a *minimum* of time at the dressing table when you furnish them with Baby-San.

For Baby-San provides a *complete* bath without any preparation or bother. Because it is highly concentrated, a few drops quickly form a mountainous lather. In one simple bathing, it quickly removes the vernix. Its high olive oil content lubricates the skin, avoids the use of other oils or greases.

No other baby soap is as efficient as purest, liquid, Castile Baby-San. That is why Baby-San—dispensed from portable Baby-San Dispensers*—is the choice today in *more than* 75% of the nation's nurseries.

*Furnished free to users of Baby-San

The HUNTINGTON LABORATORIES Inc.

DERVER

HUNTINGTON INDIANA

TORONT

BABY-SAN

AMERICA'S FAVORITE BARY SOAF

Made by the makers of Germa-Medica America's Finest Surgical Soop

NEW PRODUCTS

Improved Rolling Stock

Hospitals, when you stop to think of it, almost run on wheels. Certainly a large part of their equipment does. So when somebody pops up with an idea of improving the hospital rolling stock, administrators incline an attentive ear.

A new idea for increasing the manageability of stretchers is the double lock caster of Jarvis & Jarvis, Inc., Palmer, Mass. One operation of the foot lever causes the swivel to lock in order to make the caster run in a straight course. This makes it possible for the stretcher equipped with one caster at each end to be operated from either end. The second operation of the foot lever locks the wheel from rolling. Therefore, if need be, the stretcher can be prevented from moving at all and can be used, according to Jarvis & Jarvis, as an emergency operating table.

The caster can be attached not only to new stretchers but also to those already in use, whether of tubular or angle construction.

Whose Baby?

The sententious crack about its being a wise father who knows his own child wasn't originally applied to baby mix-ups in hospitals. But it does, just the same. According to the press, there have been several cases in which parents have had disturbing doubts as to whose baby was whose.

Infant identification, however, need no longer be a matter of guesswork since Dr. Gilbert P. Pond's development of palmprinting, which is claimed to provide positive identification not only in infancy but throughout the life of the individual.

The outfit for taking palmprints as supplied by the Physicians' Record Company, 161 West Harrison Street, Chicago, includes the following equipment: card plate of stainless steel for holding the record for printing; ink plate of stainless steel for inking the infant's palm; identification ink; roller; records for male and female infants; bottles for the three cleansing fluids; magnifying glass for examining prints; tray with compartments for the infant and for the supplies used in printing, and a steel cart on to which the tray fits. This cart is equipped with casters so that it may be moved to the delivery rooms.

A manual is being prepared which will describe the technic of palmprinting and which will present the palmprint classification for filing.

Raining Death—to Germs

There is nothing like a good coat of tan, we are informed, to make a side of beef or a leg of lamb more appetizing and less expensive. This information comes to you, via us, from the lamp division of the Westinghouse Electric and Manufacturing Company, Bloomfield, N. J., which is announcing a new line of Sterilamps and equipment for use in "Rentschlerizing."

As pasteurization is known as a means of sterilizing through the use of heat, so the Rentschler-James process or "Rentschlerizing" is a means of sterilizing through the use of selected ultraviolet radiations. The Sterilamps are slender

TS

run on does. So ving the tive ear. tretchers Palmer, wivel to course. vith one d. The el from revented Jarvis &

r angle er who o baby cording parents whose.

ners but

matter nent of dentifiof the by the Street, late of k plate

ication les for nining nd for which that it

e the palm-

rmed, tizing

c and is anor use

lizing ess or e use ender

PITAL

THE BEST HOSPITAL SERVICE I'VE EVER EXPERIENCED!...

HAT'S what patients say who have occasion to use the Standard Electric Nurses Calling System. Special call button used by patient renders double service. A slight push of button turns on a light at the call board. If this does not attract nurse, a further push of the button turns on a buzzer. The resultquicker service for the patientgoedwill for the hospital.

For complete information on Standard Electric Hospital Signalling Systems, write

THE STANDARD ELECTRIC TIME CO. Offices in Principal Cities Springfield, Mass. "STANDARD MAKES EVERY MINUTE COUNT"





Craftsmen in the art of paper making for 58 years. Distributed by reliable paper merchants everywhere.

Made Right Priced Right

A New Self-Identifying Medicine Glass Cover



The dust-free service of medications, insured by this cap, is worth far more than the few hundredths of a cent it costs. The caps fit accurately on 1-ounce medicine glasses such as Sharp & Smith's No. HG-4237. They are made of waxed material, and have a printed inset in the top on which the necessary data may be written with pencil or pen.

PRICE—Per thousand \$3.50 10 per cent discount in lots of 5000

SHARP & SMITH 1813-23 ST. LOUIS, OLIVE ST. MISSOURI HOSPITAL DIVISION A. S. ALOE CO.

KEWAUNEE Laboratory Wall Table with KARCITE SINK



Perhaps your laboratory needs new furniture. If so, write at once for the Kewaunee Catalog of Metal Scientific Laboratory Furniture. It explains complete details of the above pictured wall table and many other hospital laboratory pieces. It will be mailed without charge to buyers. Write for it on your institution's letterhead.

Revounce Tyg. Co.
LABORATORY FURNITURE GENERALS

C. G. Campbell, Pres. and Gen. Mgr. 112 LINCOLN ST., KEWAUNEE, WIS.

Eastern Branch: 220 E. 42nd St., New York, N. Y. Mid-West Office: 1208 Madison St., Evanston, Ill.

Representatives in Principal Cities



TRUSTWORTHY

We should like to throw some light on the why of Aznoe's preference by applicants and employ-

ers when it comes to placing men and women in white as:

- -administrators
- -directors of nurses
- -assistant directresses
- -instructors of nurses
- -operating room supervisors
- -obstetrical nurses
- -anesthetists
- -general duty nurses
- -dietitians
- -housekeepers
- -pharmacists
- -laboratory and x-ray technicians
- -hydrotherapists

Their loyalty is based upon Aznoe's reputation for keeping the trust of applicants and employers -of serving the best interest of each . . . of securing the best position or the best employee for each

. . . always.





CENTRAL REGISTRY FOR NURSES AND PHYSICIANS' EXCHANGE

EXECUTIVE OFFICE: 820 . 30 N. MICHIGAN AVENUE CHICAGO, ILLINOIS

rod shaped glass tubes with effective lengths of 10, 20 or 30 inches. They operate on the gaseous discharge principle in an atmosphere of inert gases and mercury vapor. More than 80 per cent of the radiant energy produced by the Sterilamp is in the region of 2550 angstroms, which provides the most effective bactericidal energy for the power consumed. The Sterilamp is operated by a power unit consisting of a transformer, relay, starting button and safety door switch.

Installation of this equipment in a meat storage refriger. ator, the Westinghouse Company claims, reduces meat loss from mold, trimming and dehydration. It is said to be necessary to chill the meat only enough to prevent flabbiness and to render it firm enough to cut readily and neatly. The refrigerator temperature can be raised to 40° F. but not exceeding 45° F.

These are the same lamps that can be used in sterilizing the atmosphere of operating rooms or in sterilizing drinking glasses and eating utensils.

Getting Ice Without Heat

If winter winds are not so cold as man's ingratitude, as Shakespeare claims, man's ingratitude is practically hot compared with a tray of solidly frozen ice cubes that stubbornly resist all efforts to release them, freezing the fingers and raising to the boiling point the temper of the nurse who has to wrestle with it.

Mindful of the fact that releasing the cubes is a source of great woe, the General Electric Company, Nela Park, Cleveland, incorporated a cube release feature in its new ice cube maker which, it is claimed, does away with the difficulty by making possible dry cube extraction at the rate of two cubes per second. With progressive freezing the trays on the top shelves freeze first and those on the remaining shelves are frozen progressively.

According to General Electric, in addition to freezing ia cubes, this new device may be used for freezing ice packs. When used for this purpose, the ice cube freezing trays are removed and the ice caps, bags or collars are placed directly on the freezing shelves. A 10 per cent alcohol solution in the bag and 5 per cent alcohol solution in the collar are recommended.

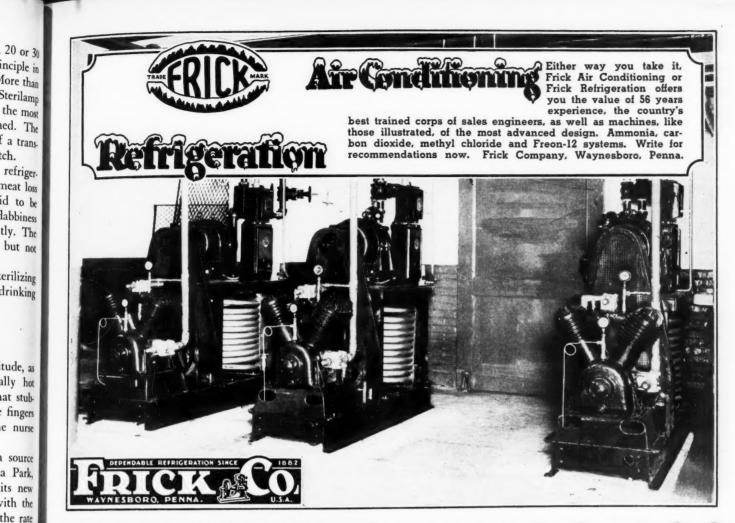
The ice cube maker freezes 400 ice cubes from a single charging. It is equipped with 20 trays and a large storage pan for a reserve supply of cubes.

Mechanical Memory Prodder

"But You Forgot to Remember," Irving Berlin's tearjerking ditty, has probably caused many an absent-minded soul to wince guiltily and wonder what he has forgotten this time. It remained for a resourceful genius (probably absent-minded himself) to produce a glorified alarm clock guaranteed to do your remembering for you. As many as forty-eight appointments or duties in one day can be registered on the James Remind-O-Clock, manufactured by the Remind-O-Clock Corporation, 1241 High Street, Oakland, Calif.

Suppose you have an important meeting with the board of trustees and want to get a haircut before you go. Just press a lever for 2:30 o'clock and right on the dot the clock will notify you that it's time to get going. The notifying is done by a buzzer that may be adjusted to any desired tone. Of course, if you can't remember what it was you wanted

Vo





Which of these Guaranteed Fly-Killers would you like us to mail you full information about-

1-Durobar Electric Screens for Doors

(Kill the Fly before he gets in)

- 2-Durobar Electric Fly Traps
 - (Kill him if he gets in)

3—Durobar Electric Panels

(Kill him away from the building by luring him to destruction with a light.)

This equipment is absolutely harmless and SAFE for people and animals . . . but SURE DEATH to Flies and all other Flying Pests.

Guaranteed—Fully perfected—For Homes, Factories, Stores, Farms and Institutions—and in use all over the country today.

COST IS LOW—Screens begin at \$12, Traps, at \$17.50, Panels at \$25. Transformers begin at \$10.50. And if you want Guards to further protect the Screens, they are from \$3.50. Installation is simple.

For completely descriptive illustrated literature

SEND COUPON · · · NOW!

Without	Street, Chi obligation se es and users	nd complete information, illustrations,	prices
B	Durobar Elect	or:— ric Screens for Doors and Windows. ric Fly Traps for inside use. len Panels for Porches or Gardens.	
FIRM			
ADDRESS			
CITY		STATE	

Vol. 51, No. 1, July 1938

tch.

ing the remain-

zing ice

packs.

ays are directly

tion in

lar are

single

storage

s tearninded rgotten

obably

clock

any as an be

red by Oak-

board . Just

clock ing is

tone.

ranted

PITAL



MONTGOMERY ELEVATORS



You can depend on MONTGOMERY SELF-LEVELING EL-EVATORS when an

emergency case needs immediate attention. Swift, quiet, always dependable service in hundreds of hospitals throughout the country proves the wisdom of installing MONTGOMERY equipment. Unmatched operating economy makes MONTGOMERY ELEVATORS a fine investment for your hospital.

ALL TYPES AND SIZES OF HOSPITAL ELEVATORS AND ELECTRIC DUMB WAITERS

Write for any Information about Hospital Elevators



Specialists in Building Elevators for Hospitals

HOME OFFICE AND FACTORY . . . MOLINE, ILLINOIS

Branch Offices and Agents in Principal Cities

USERS OF BERBECKER NEEDLES



BAYLAR UNIVERSITY HOSPITAL DALLAS, TEXAS

Founded in Dallas in 1909 by the Baptist Convention of Texas to provide systematic Christian and scientific medical care of the sick. Later became an able arm of Baylar U.—an institution chartered under the Republic of Texas, and older than the state itself! A finely equipped, competently staffed hospital of major importance throughout a wide area.

JULIUS BERBECKER & SONS, INC.
MADE IN 15 E. 26th St., New York, N. Y.

BERBECKER

BERBECKER

BORGEONSIVE

NON-CORROSIVE

NON-CORROSIVE

SEE HOSPITAL YEARBOOK, PAGES 261-272

SEE HOSPITAL YEARBOOK, PAGES 261-272

FOR COMPLETE BERBECKER

NEEDLE CATALOG

to be reminded of, the clock can't help you. You'll have to wait until someone invents a machine to do all your thinking for you.

In addition to its services as a mechanical memory, the Remind-O-Clock, we are informed, controls the flow of electric current to small electrically operated equipment or machinery, not only remembering to turn it on and off at any desired moment but actually performing the service.

The Wetter the Water the Better

Heat without humidity may be the ideal of the perspiring public, but humidity is an equal partner with heat in "hydro-massage," which is a coined word describing the effects of aqueous conductive heat combined with underwater massage.

For this type of treatment a portable tank which can be brought to the patient's bedside has been introduced by the Ille Electric Corporation, 386 Fourth Avenue, New York. The unit consists of a stainless steel tank mounted on four 4 inch solid rubber casters, an electric turbine ejector, immersion heater, dial thermometer and electric pump.

The tank can be filled from any faucet and mixed to the desired degree of temperature as indicated by the thermometer, the manufacturer claims. Drainage is accomplished by the electrically driven pump that forces the water through a swivel nozzle into any convenient basin. This tank performs the same general functions as the tank designed by Dr. J. D. Currence, described in our April issue.

Paging New Literature

Inside Information—Clean steam from dirty water does not grow. That may sound a little involved but it is a truth which the Elgin Water Softener Corporation, Elgin, Ill., has been propounding for these many years. The latest educational effort is a revised edition of the booklet, "Inside Story of Boiler Water Conditioning." The purpose of the treatise, according to the manufacturer, is to explain in simple nontechnical terms the conditions most frequently encountered and to discuss the various methods of softening, treating water and removing concentrations from the boiler. All of which it does. A copy is available for the asking.

Things and People—Congratulations are in order to several birthday celebraters. First in chronological sequence is J. A. Deknatel & Son, Inc., of Queens Village, Long Island, N. Y., which has polished off its seventieth milestone. By way of announcing the occasion the organization has published a house paper for the purpose of supplying its friends and customers with information about itself.

THE ELECTRIC STORAGE BATTERY COMPANY, Allegheny Avenue and 19th Street, Philadelphia, began in June to observe its golden anniversary year.

July marks the twenty-fifth birthday of the Kent Company, Inc., 113 Canal Street, Rome, N. Y.

Many happy returns.

DR. WILLIS RODNEY WHITNEY, General Electric vice president in charge of research, was awarded the Marcellus Hartley gold medal by the National Academy of Sciences at its annual meeting in Washington. The award is given "to mark the appreciation of the National Academy of Sciences for eminent services to the public, performed without a view to monetary gains and by methods which, in the opinion of the academy, are truly scientific."